Supreme Court, U.S.
FILED

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No. ____

IN THE
SUPREME COURT OF THE UNITED STATES

October Term, 1995

ST. PETER VILLA, INC.; PRESBYTERIAN HOMES OF TENNESSEE, INC.; RHA/SULLIVAN, INC.; CEDARS HEALTH CARE CENTER, INC; MCKENDREE VILLAGE, INC. *Petitioners,*

v.

MILDRED LEA LINTON by her next friend KATHY ARNOLD, on her own behalf and on behalf of all other persons similarly situated; BELLE CARNEY, by her next friend MARY KIMBLE, on her own behalf and on behalf of all other persons similarly situated; COMMISSIONER OF HEALTH AND ENVIRONMENT, STATE OF TENNESSEE, *Respondents.*

Petition for a Writ of Certiorari
To the United States Court of Appeals
For the Sixth Circuit

PETITION FOR WRIT OF CERTIORARI

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QUESTION PRESENTED FOR REVIEW

Whether the Court of Appeals erred by affirming the District Court's remedial plan without addressing Title VI liability when: (1) the District Court found violations of both the Medicaid Act and Title VI, ordered the preparation of a remedial plan to address Title VI, and the plan was submitted by the Respondents to remedy both violations; and (2) the remedial plan includes remedies for racial discrimination.

LIST OF PARTIES

The only parties to this preceeding are those listed in the caption. None of the corporations listed as Petitioners has either a parent corporation or a nonwholly owned subsidiary.

TABLE OF CONTENTS

	Page(s)
QUESTION PRESENTED FOR REVIEW.	i
LIST OF PARTIES.	ii
TABLE OF CONTENTS.	iii-v
TABLE OF AUTHORITIES.	vi-ix
OPINIONS OF THE COURTS BELOW.	1
JURISDICTIONAL STATEMENT.	2
CONSTITUTIONAL AND STATUTORY PROVISIONS INVOLVED.	3
STATEMENT OF THE CASE.	4-11
REASONS FOR ALLOWANCE OF THE WRIT.	11-26

A. THE REMEDIAL PLAN ADDRESSES BOTH THE MEDICAID ACT AND TITLE VI VIOLATIONS.. 11-18

B. PETITIONER APPEALED THE DISTRICT COURT'S FINDING OF A TITLE VI VIOLATION AND THE REMEDIAL PLAN TO THE COURT OF APPEALS. 19-22

C. THE COURT OF APPEALS ERRED IN NOT FIRST ADDRESSING LIABILITY UNDER TITLE VI BEFORE REVIEWING THE REMEDIAL PLAN AS A CONSENT REMEDY. 22-24

D. THE COURT OF APPEALS ERRED IN NOT FIRST ADDRESSING LIABILITY UNDER TITLE VI WHEN THE REMEDIAL PLAN INCLUDES REMEDIES FOR RACIAL DISCRIMINATION. 24-26

CONCLUSION. 27

APPENDIX CONTENTS

Sixth Circuit En Banc Order. 1a-2a

Sixth Circuit Opinion. 3-23a

District Court Final Order. 25a-26a

State's Remedial Plan. 27a-99a

District Court Order Entered 4/23/90. . . . . 101a

District Court Memorandum
Entered 4/23/90. . . . . 103a-123a

Public Necessity Rule Notice. 125a-148a

T.C.A. § 68-1-113. . . . . 149a-150a

Excerpts from Pet. Sixth Circuit Brief. . . . 151a-152a

Excerpts from Affidavit of Fred Bean. 153a

Excerpts from Medicaid Act
42 U.S.C. § 1396r(c). 155a-156a

Trial Exhibit to Testimony
of Polly T. Darnall. 157a-159a

TABLE OF AUTHORITIES

Cases Cited:	Page(s)
Alexander v. Choate, 469 U.S. 287 (1984).	16
Bumpus v. Clark, 681 F.2d 679 (9th Cir. 1982).	18
Crowder v. Housing Authority of City of Atlanta, 990 F.2d 586, 593 (11th Cir. 1993) and 908 F.2d 843, 845 (11th Cir. 1990).	14
Hearth, Inc. v. Dept. of Public Welfare, 617 F.2d 381 (5th Cir. 1980).	18
Illinois Physicians U. v. Miller 675 F.2d 151, 158 (7th Cir. 1982). . . .	18
Jews for Jesus, Inc. v. MBTA 984 F.2d 1319, 1327 (1st Cir. 1993). .	14

LaShawn A., By Moore v. Kelly,
990 F.2d 1319 (D.C. Cir. 1993). . . . 21

Linton v. Commissioner,
65 F.3d 508
(6th Cir. 1995). 10

Local No. 93, International Assn of Firefighters v. Cleveland,
478 U.S. 501 (1986). 23

Martin v. Wilkes,
490 U.S. 755 (1989). 12

Minnesota Assn. of Health Care Facilities v. Minn. Dept. of Public Welfare,
602 F.2d 150 (8th Cir. 1979). 18

Newfield House v. Mass. Dept. of Public Welfare,
651 F.2d 32 (1st Cir. 1981). 18

Pennhurst State Sch. & Hospital v. Halderman ,
451 U.S. 1 (1981). 21

United States v. Starrett City Associates,

840 F.2d 1096 (2nd Cir. 1988). 14

Suter v. Artist M.,
503 U.S. 347 (1992). 19

Wards Cove Packing Co.
v. Atonio,
480 U.S. 642 (1985). 19

Whitney v. Heckler,
780 F.2d 9673 (11th Cir. 1986). 18

Wilder v. Bernstein,
848 F.2d 1338 (2nd Cir. 1988). 15

Wilder v. Virginia
Hospital Association,
496 U.S. 498 (1990). 19

Other:

28 USC § 1331. 2

28 USC § 1343(3). 2

42 USC § 1983. 2

28 USC § 1254(1)(1988). 2

TITLE XIX OF THE
SOCIAL SECURITY ACT
42 USC § 1396. 3

TITLE VI OF THE
CIVIL RIGHTS ACT OF
1964
42 USC § 2000d. 3

MEDICAID ACT AND
TITLE VI. 7

MEDICAID ACT
AT 42 USC § 1396r(c)(5)(A). 13



PETITION FOR WRIT OF CERTIORARI TO THE UNITED STATES COURT OF APPEALS FOR THE SIXTH CIRCUIT

II. OPINIONS OF THE COURTS BELOW

The Memorandum and Order of April 23, 1990, of the District Court is reported at 779 F. Supp. 925 (M.D. Tn. 1990) and is reprinted at pages 101a-123a of the Appendix hereto. The Final Order of the District Court and the remedial plan incorporated by reference therein are unpublished and reprinted at pages 25a-99a of the Appendix. The United States Court of Appeals for the Sixth Circuit has issued three published opinions in this matter. At 973 F.2d 1311 (6th Cir. 1992) and 30 F.3d 55 (6th Cir. 1994), the Court of Appeals addressed Petitioners' intervention and standing. The opinion on the merits by the Court of Appeals is reported at 65 F.3d 508 (6th Cir. 1995) and is included in the Appendix at pages 3a-23a. The order denying the Petition for Rehearing and Suggestion for Rehearing En Banc is unreported and is reprinted in the Appendix at pages 1a-2a.

III. JURISDICTIONAL STATEMENT

The jurisdiction of the District Court was invoked pursuant to 28 U.S.C. § 1331 (federal question) and 28 U.S.C. § 1343 (3), which provides for original jurisdiction of suits authorized by 42 U.S.C. § 1983. On July 5, 1990, the District Court entered a final order in this cause. Petitioners intervened and timely appealed that final order to the Court of Appeals, which affirmed the decision of the District Court on September 15, 1995. Petitioners filed a petition for rehearing and suggestion for rehearing en banc which was denied by the Court of Appeals in an order filed October 23, 1995 A. 1a-2a. This Petition for Certiorari is being timely filed within 90 days of that denial.

Jurisdiction of this Court is invoked under 28 U.S.C. § 1254 (1) (1988).

IV. CONSTITUTIONAL AND STATUTORY PROVISIONS INVOLVED

1. Title VI of the Civil Rights Act of 1964, 42 U.S.C. § 2000d.

> No person in the United States shall, on the ground of race, color or national origin, be excluded from participation in, be denied the benefits of, or be subjected to discrimination under any program or activity receiving Federal financial assistance.

2. Title XIX of the Social Security Act, 42 U.S.C. § 1396 et. seq. (Medicaid Act) (pertinent portions set forth verbatim in the text or in the Appendix).

V. STATEMENT OF THE CASE

At the time of the initiation of this litigation in 1987, the State of Tennessee received federal financial assistance to provide medical assistance to eligible individuals pursuant to Title XIX of the Social Security Act, 42 U.S.C. § 1396 et seq. (Medicaid Act). Tennessee's approved state Medicaid plan provided reimbursement for skilled nursing services in a skilled nursing facility (SNF) and for less intensive intermediate care services in an intermediate care facility (ICF). In order to receive Medicaid reimbursement for such services, a nursing home was required to be certified as an ICF or SNF provider or both. A. 105a-107a.

At that time, 272 of the 286 licensed nursing homes in Tennessee (over 95%) participated in Medicaid at either the SNF or ICF level or both. A. 157a. Tennessee certification policies permitted participating nursing homes to certify all, some or none of their beds for participation in the skilled or intermediate programs, and beds could be "dually certified" for both skilled and intermediate care as well. A. 4a-5a.

Of the 272 facilities participating in the Medicaid program, 209 (almost 77%) chose to certify all of their available beds. The remainder chose to have one or more beds noncertified. Statewide, there were 31,448 beds in participating facilities, of which 29,397 (over 93%) were certified. A. 157a.

Licensed nursing homes derived approximately 70%

of their revenues from Medicaid. A. 4a. Medicaid payment rates for skilled care were higher than for intermediate care due to the greater needs of skilled care patients. Unlike Medicaid rates, which were established by the state, private pay patients' rates were substantially higher and were set by the market. As a result, nursing homes preferred private paying patients. A.112a.

In those participating facilities which were not fully certified, noncertified beds were used (reserved) for private paying patients. A. 112a. If these patients later became eligible for Medicaid, the facility could ask that the individual bed be certified (spot certified) for Medicaid participation or could transfer or discharge the patient to a bed or facility which was certified for the level of care required. A. 112a.

In those participating facilities which were fully certified for Medicaid participation, private paying patients could be preferentially admitted. A. 153a. However, they could not be involuntarily transferred or discharged if their payment source later changed to Medicaid because the entire facility was noncertified under the Medicaid program.[1]

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[1] At 42 U.S.C. § 1396r(c)(2)(A), the Medicaid Act provides in pertinent part as follows:

> (2) Transfer and discharge rights
>
> (A) In general
>
> A nursing facility must permit each resident to remain

At the time of initiation of this litigation, Respondent Mildred Lea Linton (Plaintiff below), an elderly white woman, was a skilled care Medicaid patient at a Tennessee nursing facility which certified some, but not all, of its beds for participation in the Medicaid program. Due to a State determination that she no longer needed skilled care and the stated intention of the facility to decertify her bed for intermediate care, she was threatened with transfer or discharge from the facility. A. 104a.

On December 9, 1987, Respondent Linton filed the Complaint in this cause against the Respondent Commissioner of Health and Environment (Defendant

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in the facility and must not transfer or discharge the resident from the facility unless-

(i) the transfer or discharge is necessary to meet the resident's welfare and the resident's welfare cannot be met in the facility;

(ii) the transfer or discharge is appropriate because the resident's health has improved sufficiently so the resident no longer needs the services provided by the facility;

(iii) the safety of individuals in the facility is endangered;

(iv) the health of individuals in the facility would otherwise be endangered;

(v) the resident has failed, after reasonable and appropriate notice, to pay (or to have paid under this subchapter or subchapter XVIII of this chapter on the resident's behalf) for a stay at the facility; or

(vi) the facility ceases to operate.

below).[2] Although Linton's complaint raised numerous issues and claims, the claim involved in this petition alleged that the State's policy which permitting Medicaid participating facilities to certify less than all their intermediate care beds for participation (limited bed certification) violated the Medicaid Act. Furthermore, she alleged that the State improperly permitted participating nursing homes to spot certify (or decertify) an individual bed which was not contiguous with other certified beds (spot certification).[3] A. 7a.

On December 11, 1987, two days after the complaint was filed, Respondent Belle Carney filed a Motion to Intervene and a Complaint in Intervention. Subsequently, the District Court granted Carney permission to intervene as a plaintiff. Like Linton, Carney alleged that Tennessee's certification policies violated the Medicaid Act. However Carney, who is black, also alleged that the Tennessee certification policies caused a disparate impact on minorities in violation of Title VI of the Civil Rights Act of 1964, 42

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[2] Although the complaint named the Commissioner of the Department of Health and Environment of the State of Tennessee as defendant, the name of the state agency subsequently changed to the Department of Health and, in 1995, the responsibility for the Tennessee Medicaid Program was shifted to the Commissioner of the Department of Finance and Administration. For simplicity, Petitioners will refer to the state Respondent as the "State."

[3] The Petitioners will refer to these policies jointly as the "Tennessee certification policies."

U.S.C. § 2000d, et seq. (Title VI).

Carney was not a resident of a Tennessee nursing home, but she alleged that as a result of the challenged policies her access to needed nursing home services was impaired. A. 6a, 105a.

On April 23, 1990, the District Court entered a Memorandum and Order concerning the liability issues under the Medicaid Act and Title VI. The District Court found that the Medicaid Act required that a participating facility must certify all of its beds for Medicaid participation and, therefore, the state's policy permitting less than full certification violated the Medicaid Act. As a basis for its Title VI holding the District Court also found that the limited bed policy which permitted participating nursing homes to reserve a portion of their beds solely for private paying patients caused a disparate impact on minorities in violation of Title VI. The District Court principally relied upon a finding that 39.4% of the Medicaid recipients (all ages and services) were black and only 15.4% of the Medicaid recipients in nursing homes were black. A. 113a-114a. In the Memorandum, the District Court declared the challenged Tennessee certification policies to be in violation of the Medicaid Act and Title VI and ordered the State to "submit a plan for Court approval that will redress the disparate impact on minority Medicaid patients' access to qualified nursing home care." A. 25a-26a.

On June 1, 1990, the State submitted a remedial plan to which Linton and Carney did not object. The District

Court adopted this remedial plan and incorporated it into the final order entered on July 5, 1990.

Among other things, the plan:

- Required that Medicaid participating facilities certify 100% of their beds (full certification). A. 31a-32a.

- Prohibited involuntary transfer or discharge of a resident because the resident's source of payment was Medicaid. A. 31a-34a.

- Mandated a first come, first served admissions from a single wait list. A. 34a-37a.

- Implemented measures designed to prevent provider attrition (lock in and lock out). A. 31a, 37a-41a.

- Required retention of a resident during the pendency of Medicaid appeals of a denied pre-admissions evaluation (PAE). A. 33a.

- Expanded the Minority Applicant Pool System (MAPS) to include all four metropolitan areas of the State. A. 44a-45a.

- Established monitoring and evaluation standards for minority utilization of nursing home services to determine Title VI compliance. A. 45a-46a.

- Provided for affirmative action plans for facilities found to be non-compliant with Title VI. A. 46a-48a.

- Established civil rights enforcement measures including denial, suspension or revocation of a facility's license and imposition of civil monetary penalties. A. 48a.

These provisions are described further below.

On July 30, 1990, petitioners intervened for purposes of appeal. On appeal, petitioners challenged the Title VI liability finding and the remedial plan adopted by the District Court. A. 151a-152a. The Court of Appeals affirmed the entire remedial plan without addressing the District Court's finding of a Title VI violation on the ground that the plan could be justified on the basis of the Medicaid Act violations found by the District Court.[4] *Linton v. Commissioner*, 65

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[4] The Court of Appeals failed to address the enforceability of Plaintiffs' claims under the Medicaid Act which was raised by the Petitioners.

F.3d 508 (6th Cir. 1995). A. 3a-23a.

VI. REASONS FOR ALLOWANCE OF THE WRIT

This petition raises a novel issue due to an egregious error of the Court of Appeals which should be corrected through the supervisory powers of the Supreme Court. In essence the Court of Appeals erroneously affirmed the remedial plan without addressing Petitioners' challenge to the underlying Title VI violation.

A. The remedial plan addresses both the Medicaid Act and Title VI violations.

The remedial plan was implemented by the state through regulations placing mandatory requirements on participating nursing homes. These regulations were promulgated outside the normal rulemaking process and under the authority of the District Court's Order. A. 125a-148a.[5]

The plan broadly affects the delivery of Medicaid nursing home services in Tennessee. Despite the lack of

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[5] By promulgating regulations under the authority of the District Court's Order, the state agency could bypass and avoid full public participation rights and make legislative oversight ineffectual.

industry input into the formulation of the plan, the burdens directly and adversely fall upon nursing home providers.[6]

The remedial plan contains many significant program changes. One such change requires Tennessee nursing homes to certify all of their beds if they participated in Medicaid. A. 31a-32a.

The remedy of full certification directly and fully addresses the District Court's finding that the State's limited bed certification policies violated the Medicaid Act. In addition, the Court prohibits the involuntary transfer or discharge of a resident because the resident's source of payment is Medicaid. A. 31a-34a. The effect of these remedies is to bring the State into compliance with the Medicaid Act as interpreted by the District Court. It should be noted that these two remedies resolve the Respondent Linton's claims and protect her from future threats of transfer or discharge.

The District Court's remedy went well beyond the remediation of the alleged Medicaid Act violations, however, to address matters that clearly relate to Title VI. One provision of the plan requires that participating facilities admit patients in chronological order of application, *i.e.*, on

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[6] Much like the situation in *Martin vs. Wilkes* 490 U.S. 755 (1989) where the governmental entity entered into a consent decree with black plaintiffs in a Title VII case but the real burden of the decree fell upon white firefighters, the Respondents here would find it easy to agree to remedies which principally impacted nursing home providers.

a "first come first served" basis. A. 34a-37a.

First come first served admission begins with a requirement that nursing facilities place all admission inquiries in chronological order on a single waiting list. Admission to the facilities are to be in the order shown on the waiting list. Facilities are not permitted to give preference for:

- Religion, including facilities which are religiously affiliated.

- Contract, including those facilities which have contractual obligations to provide services to prospective residents (typically retirement communities, insurance companies and hospitals resident arrangements).

- Private paying residents, including those with long term care insurance.

- Resident diagnosis or level of care, including admission to special care units such as those providing services for rehabilitation or stroke patients.

This first come first served remedy relates solely to

admissions.[7] It does not apply solely to the few beds that previously were noncertified (7%) or to the few facilities which were not fully certified (23%). Instead, it applies to all nursing homes which participate in Medicaid.

Moreover, first come first served admissions are not required by the Medicaid Act.[8] In reality, the first come first served remedy is a form of affirmative action which addresses the disparate impact on minorities' utilization of nursing home services found by the District Court.[9]

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[7] In fact, the implementing regulations contained in the remedial plan are entitled "Admission to intermediate care facilities and skilled nursing facilities." A. 66a.

[8] The Court of Appeals seriously misconstrued the Medicaid Act when it found that "admission decisions may not be based upon eligibility or future eligibility for Medicaid" A. 14a Nothing in the Medicaid Act prohibits discrimination on admission based upon source of payment. The Act at 42 U.S.C. § 1396 (C)(5)(A) prohibits certain admissions practices none of which include discrimination based on source of payment. A. 155a - 156a. In fact the Act specifically provides that states may choose to have stricter laws governing admissions which prohibit Medicaid discrimination 42 U.S.C. § 1396n (C)(5)(B), A. 156a. Moreover, the prior section of the Act which deals with transfer and discharge and provision of service to individuals already admitted to the facility expressly prohibits discrimination based upon source of payment. 42 U.S.C. § 1396n (C)(4)(A), A. 155a. Clearly Congress intended that Medicaid discrimination be prohibited in the first instance but not in admissions.

[9] "First come - first served" has been utilized in other constitutional areas, see eg. *Jews for Jesus, Inc. v. MBTA*, 984 F.2d 1319, 1327 (1st Cir. 1993) (first come - first serve is not a time, place or manner restriction which would violate the First Amendment). *Accord, Crowder v. Housing Authority of City of Atlanta*, 990 F.2d 586,

The Respondents also agreed to impose a remedy which requires participating nursing homes to retain a resident during pendency of Medicaid appeals of a denied pre-admission evaluation (PAE), a remedy unrelated to any of the allegations of the Complaint. A. 33a.[10] The effect of this remedy is to require nursing homes to retain residents for lengthy periods of time after the state has determined initially that the resident does not medically qualify for Medicaid reimbursement. As a result, the facility must provide services for this time to a resident who is, by definition, poor, with little or no expectation of payment.

The remedial plan also contains several remedies that are explicitly race-based and are specifically designed to address the District Court's concerns with minority access. These remedies are totally unrelated to limited bed certification and include expansion of the Minority Applicant Pool System (MAPS), establishment of Title VI monitoring and compliance standards and affirmative action for non-compliance. A. 44a-48. The MAPS program was designed

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593 (11th Cir. 1993) and 908 F.2d 843, 845 (11th Cir. 1990); *United States v. Starrett City Associates*, 840 F.2d 1096 (2nd Cir. 1988) (prohibiting a non first-come first served quota system for allocating public housing); *Wilder v. Bernstein*, 848 F.2d 1338 (2nd Cir. 1988) (approving a modified first come - first served method of placing children in private foster care agencies).

10 A Medicaid resident must be qualified both financially and medically to receive Medicaid reimbursement for nursing facility services. The PAE is used to determine medical qualification for those services.

to identify and refer minority applicants to nursing facilities. A. 45a. The Title VI monitoring and compliance standards included in the remedial plan establish the State's methodology for determining whether a particular nursing home has a sufficient population of minority residents and staff to be in compliance with Title VI. A. 45a-46a. In the event of non-compliance, the remedial plan proposes methods of achieving compliance including imposition of affirmative action plans for preferential admission of minority patients. A. 46a-48a.

Further, the remedial plan contains regulations establishing civil rights sanctions against nursing homes. A. 81a-87a. In response to the District Court's finding that discrimination against Medicaid recipients resulted in a disparate impact in violation of Title VI, the Respondents incorporated a prohibition against "method of payment" discrimination in addition to race, color and national origin.[11] These regulations provide for civil penalties up to $5,000 and specifically include failure to admit on a first come first served basis as a violation. The Tennessee statute authorizing promulgation of theses civil rights penalties, like Title VI itself, prohibits discrimination based on race, color or

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[11] The Title VI theory propounded by Carney and adopted by the District Court is based upon the proposition that because blacks are disproportionally represented in the Medicaid program, any discrimination against Medicaid as a source of payment automatically results in a disparate impact in violation of Title VI. This theory is markedly similar to the one advocated to this Court and rejected in *Alexander v. Choate*, 469 U.S. 287 (1984).

national origin. A. 149a. State law and the Medicaid Act neither authorize nor require that civil penalties be assessed for method of payment discrimination. Therefore, method of payment civil penalties have been imposed without statutory authorization on Tennessee nursing homes by the District Court at the behest of the Respondents.

Finally, the District Court also expressed concerns that provider attrition and displacement of current Medicaid patients could result from its ruling. A. 7a. Therefore, it ordered the state to include prophylactic measures to prevent that result. One such measure, "lock-in," prevents facilities which desired to leave the Medicaid program from transferring or discharging their current Medicaid patients. Lock-in was designed to force withdrawing facilities to involuntarily participate in the Medicaid program until the last current Medicaid patient died or voluntarily left the facility. A. 40a.[12]

Lock-out refers to another provision of the remedial plan. It prevents the withdrawing facility from re-entering the Medicaid program for two years after the last Medicaid patient left the facility. A. 40a. Lock-out is purely a punitive remedy created to punish a withdrawing facility for having made a decision to withdraw.

Decisions by lower courts interpreting the Medicaid

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[12] In June, 1993, almost three years after approval of the remedial plan, the lock-in provision was changed to establish a new procedure for withdrawal. These procedures made lock-in optional.

Act are uniform in finding that participation by providers in Medicaid is voluntary.[13] Nursing home provider agreements include a thirty day notice requirement before termination by the provider. A. 18a. Further, the Medicaid Act expresses a clear desire that provider participation should be encouraged.[14] Therefore, the lock-in and lock-out remedies are not designed to bring the state into compliance with the Medicaid Act. Instead, these remedies conflict with the Act itself.

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[13] See, eg.. *Bumpus v. Clark*, 681 F.2d 679 (9th Cir. 1982) (withdrawn as moot, 701 F.2d 829) (nursing homes); *Illinois Physicians U. v. Miller*, 675 F.2d 151, 158 (7th Cir. 1982) (physicians); *Newfield House v. Mass. Dept. of Public Welfare*, 651 F.2d 32 (1st Cir. 1981) (nursing home); *Hearth, Inc. v. Dept. of Public Welfare*, 617 F.2d 381 (5th Cir. 1980) (nursing home); *Whitney v. Heckler*, 780 F.2d 963 (11th Cir. 1986) (physicians); *Minnesota Assn. of Health Care Facilities v. Minn. Dept. of Public Welfare*, 602 F.2d 150 (8th Cir. 1979) (nursing home).

[14] "A State plan for medical assistance must -
(30)(A)...assure that payments...are sufficient to enlist enough providers so that care and services are available under the plan at least to the extent that such care and services are available to the general population in the geographic area;"
42 U.S.C. § 1396a.

B. Petitioner appealed the District Court's finding of a Title VI violation and the remedial plan to the Court of Appeals.

Petitioners, as appellants before the Court of Appeals, raised two issues. First, Petitioners challenged the District Court's finding that the state's certification policies resulted in a disparate impact on minorities in violation of Title VI. Then, Petitioners challenged the remedial plan as an "abuse of discretion where (1) the legal predicate underlying that remedy (i.e. the disparate impact violation) is invalid, and (2) even if the disparate impact findings were valid, the remedy is not narrowly tailored to the specific violation identified by the court and is otherwise contrary to federal law."A. 151a. [15]

With respect to the Title VI argument, Petitioners showed:

- That the District Court and the Respondents failed to acknowledge and apply the proper analysis for a disparate impact case as previously announced by this Court in *Wards Cove Packing Co. v Atonio*, 480 U.S. 642

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[15] Petitioners also noted that the various portions of the Medicaid Act relied on by Plaintiffs were unenforceable under 42 U.S.C. § 1983 and the standards set forth in this Court's decision in *Wilder v. Virginia Hospital Association*, 496 U.S. 498 (1990) and *Suter V. Artist M.*, 503 U.S. 347 (1992).

(1985). A. 151a-152a.

- That there was no evidence of a comparison by the District Court of the proper groups as required by *Wards Cove*. A. 151a-152a.

- That the District Court compared the racial characteristics of the entire Medicaid population (39.4% black) to the racial characteristics of Medicaid residents of nursing homes (15.4% black). A. 114a. The Medicaid population includes large numbers of AFDC recipients and others who clearly do not need or desire nursing home services. Furthermore, the admissions to nursing homes come from sources other than Medicaid. Blacks comprise 15.8% of Tennessee's over 65 population.[16]

- That there was no expert testimony before the District Court regarding the statistical significance of any comparison.

- That there was no proof that the *de-minimus* limited bed certification (7% of participating

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16 Tennessee Statistical Abstract, 1985/86, University of Tennessee by stipulation of Respondents.

beds) caused any disparity.

- That the analysis used by the District Court in holding that discrimination against Medicaid as a payment source automatically results in a Title VI violation, by analogy, is contrary to the holding in *Alexander v. Choate*, 469 U.S. 287 (1984).

Petitioners expected that the Court of Appeals logically would examine the liability issue under Title VI before addressing the remedial plan issues. If the Title VI liability holding were found invalid, remand would be required to determine an appropriate remedy.

In *Pennhurst State Sch. & Hospital v. Halderman*, 451 U.S. 1 (1981), this Court reversed the Court of Appeals' holding that the cause of action could be brought under federal law. In remanding the case for consideration of the remedy under state law, this Court rejected the argument that the remedy could be justified solely under state law. The Court found that the holding on state law may have been colored by the holding on federal law which was reversed. The Court also found that it was unclear that the remedy could be entirely justified under state law. Similarly, in *LaShawn A., By Moore v. Kelly*, 990 F.2d 1319 (D.C.Cir. 1993), the Court of Appeals remanded the case for the District Court to revise a consent decree where the Court of Appeals upheld the holding of the District Court solely under

District of Columbia law without addressing the federal and constitutional claims.

With respect to the challenges to the remedial plan, as shown previously, Petitioners first asserted that the remedial plan adoption was an abuse of discretion if the Title VI legal predicate is erroneous. Second, the Petitioners argued that alternatively even if the Title VI finding were proper, the remedial plan was too broad because it applied the first come first served remedy to all facilities and because its lock-in, lock-out provisions violated federal law and the U.S. Constitution. A. 151a-152a.

C. The Court of Appeals erred in not first addressing liability under Title VI before reviewing the remedial plan as a consent remedy.

In reviewing the remedial plan as a consent remedy, the Court of Appeals considered whether the remedy conflicts with or violates the statute on which the Complaint was based or violates the intervenors' constitutional rights. A. 12a. Using that standard, the Court of Appeals proceeded to review specifically, the first come first served and the lock-in and lock-out provisions of the plan. By focusing directly on these provisions alone and applying the standard of review set forth above, the Court of Appeals only addressed the alternative arguments of the Petitioners which were based on an assumption that the Title VI finding

was affirmed. By doing so, the Court of Appeals failed to address the Petitioners' challenge to the entire remedial plan as based upon an invalid liability holding under Title VI.

In an effort to avoid dealing with an extremely dubious Title VI ruling by the District Court, the Court of Appeals approached the case in a backwards fashion by considering the remedial plan first without addressing the underlying Title VI liability issue. By characterizing the remedial plan as a consent remedy, the Court of Appeals was able to justify using a standard of review under which the remedy would only be reversed if illegal, unconstitutional or an abuse of discretion. *Local No. 93, International Assn of Firefighters v. Cleveland*, 478 U.S. 501 (1986), A. 12a.[17] Even if the Court of Appeals is correct in its use of the standard of review based upon language in *Local No. 93*, Petitioners submit that the essence of that case is found in its recognition of an agreement, in the nature of a contract between the litigating parties. *Id.* at 519.

The Court of Appeals failed to recognize that any "agreement" between the Respondents was made after the District Court found violations of both the Medicaid Act and Title VI and after the District Court ordered submission of

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[17] Petitioners note that *Local No. 93* differs a great deal from the instant case. In particular there was a consent decree entered in *Local No. 93* prior to trial and there was no pending challenge to an underlying liability issue. Furthermore, here the Court of Appeals interpreted *Local No. 93* as providing a hard and fast rule for reviewing all consent decrees regardless of the factual and procedural background. A 12a.

a Title VI remedial plan. Without a doubt, the Respondents negotiated, prepared and agreed to submit the remedial plan to address both violations. This is consistent with the Order requiring preparation of the plan and the remedies within the plan itself which purport to address both Medicaid Act and Title VI violations. In order for the Court of Appeals to uphold the remedial plan without addressing Title VI liability, it would have to assume that the Respondents would have entered into the same agreement if the District Court had only found Medicaid Act violations. Petitioners submit that it is inconceivable that a state agency would agree to the imposition of court ordered remedies for racial discrimination if a district court failed to find liability under Title VI. Since it is clear that the consensual nature of the agreement embodied in the remedial plan was based upon the District Court's liability findings under both the Medicaid Act and Title VI, the Court of Appeals should have addressed Title VI.

D. The Court of Appeals erred in not first addressing lability under Title VI when the remedial plan includes remedies for racial discrimination.

As a result of the Court of Appeals' failure to address Title VI, the Petitioners have been deprived of appellate review of the Title VI liability ruling and have been left with a broad remedial plan which cannot be justified by the

Medicaid Act violations. There is simply no rationale for the imposition of remedies wholly unrelated to the Medicaid Act and designed to address racial discrimination, such as affirmative action, Title VI compliance and monitoring, Minority Applicant Pool Systems and civil rights enforcement sanctions.[18]

This Court in *Pennhurst* discussed at length the scope of remedies for violation of federal laws such as the Medicaid Act based upon Congressional spending power. There the Court reiterated the well established principle that under such laws Congress may fix the terms on which it disburses federal money to the States, and that spending power legislation is contractual in nature.[19] This Court also examined the question of the appropriate remedy in cases involving spending power statutes. Although the Court accepted the principle that relief generally would be limited to declaratory relief and an injunction against payment of federal funds unless the State brought its state plan into compliance with federal law, it also recognized that other decisions achieved compliance with federal law more

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18 Including a civil monetary penalty provision not authorized by state law. See supra p. 16-17.

19 "..legislation enacted pursuant to the spending power is much in the nature of a contract: in return for federal funds, the States agree to comply with federally imposed conditions. The legitimacy of Congress' power to legislate under the spending power thus rests on whether the State voluntarily and knowingly accepts the terms of the 'contract.'" *Pennhurst* at 17.

directly.[20] Regardless, the contractual nature of these programs requires that relief focus on bringing the state program into compliance with the federal statutory requirements.

In the instant case, the District Court found that the State's "practice of allowing nursing homes in Tennessee to certify less than all of their beds as available to Medicaid patients" violated the Medicaid Act. A. 122a-123a. Thus the Medicaid Act violations were remedied easily by requiring full certification of all available beds in participating facilities. To impose unrelated remedies without reaching the Title VI issue is an abuse of discretion.

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[20] In some instances the states were enjoined from enforcing conflicting state laws and in other instances state laws were simply struck down. *Pennhurst* at 29.

CONCLUSION

For the reasons set forth above, this Petition for Writ of Certiorari should be granted.

Respectfully submitted:

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APPENDIX

Nos. 93-6142/43/44/46/47

Filed
Oct 23 1995
Leonard Green,
Clerk

UNITED STATES COURT OF APPEAL
FOR THE SIXTH CIRCUIT

MILDRED LEA LINTON, BY HER NEXT FRIEND KATHY ARNOLD, ON HER OWN BEHALF AND ON BEHALF OF ALL OTHER PERSONS SIMILARLY SITUATED,	
Plaintiff-Appellee,	
BELLE CARNEY, BY HER NEXT FRIEND MARY KIMBLE, ON HER OWN BEHALF AND ON BEHALF OF ALL OTHER PERSONS SIMILARLY SITUATED,	
Intervening Plaintiff-Appellee,	
v.	ORDER
COMMISSION [*sic*] OF HEALTH AND ENVIRONMENT, STATE OF TENNESSEE,	
Defendant-Appellee,	
ST. PETER VILLA, INC., ET AL.,	
Intervening Defendants-Appellants.	

BEFORE: JONES, GUY, and BOGGS, Circuit Judges.

The court having received a petition for rehearing en banc, and the petition having been circulated not only to the original panel members but also to all other active judges of this court, and no judge of this court having requested a vote on the suggestion for rehearing en banc, the petition for rehearing has been referred to the original hearing panel.

The panel has further reviewed the petition for rehearing and concludes that the issues raised in the petition were fully considered upon the original submission and decision of the case. Accordingly, the petition is denied.

ENTERED BY ORDER OF THE COURT

/S/
Leonard Green, Clerk

Nos. 93-6142/6143/6144/6146/6147

UNITED STATES COURT OF APPEALS
FOR THE SIXTH CIRCUIT

MILDRED LEA LINTON, by her next friend KATHY ARNOLD, on her own behalf and on behalf of all other persons similarly situated, *Plaintiff-Appellee,*	)	ON APPEAL from the United States District Court for the Middle District of Tennessee
BELLE CARNEY, by her next friend MARY KIMBLE, on her own behalf and on behalf of all other persons similarly situated, *Plaintiff/Intervenor-Appellee,*	)	
v.	)	
COMMISSIONER OF HEALTH AND ENVIRONMENT, STATE OF TENNESSEE, *Defendant-Appellee,*	)	
St. Peter Villa, Inc. (93-6142); Presbyterian Homes of Tennessee, Inc. (93-6143); RHA/Sullivan, Inc. (93-6144); Cedars Health Care Center, Inc. (93-6146); McKendree Village, Inc. (93-6147), *Defendants/Intervenors-Appellants.*	)	

Decided and Filed September 15, 1995

Before: JONES, GUY, and BOGGS, Circuit Judges.

GUY, Circuit Judge. This case involves a class action suit brought in 1987 against the Commissioner of the Tennessee Department of Health and Environment (Tennessee).[1] The plaintiffs are current or future Medicaid-eligible individuals who seek nursing facility services.[2] Plaintiffs contested the validity of Tennessee's implementation of distinct part certification under Title XIX of the Social Security Act, 42 U.S.C. § 1396 *et seq.* (Medicaid Act).[3] Under distinct part certification, a provider of

[1]At different times during the period relevant to this case, the agency was also known as the Department of Public Health. It is currently titled the Department of Health. For convenience, it is referred to throughout this opinion as "Tennessee."

[2]The certified class consists of the following persons:

> [A]ll persons who are now, or will in the future be, eligible for medical assistance benefits under the Tennessee Medicaid program, pursuant to Title XIX of the Social Security Act, and who seek nursing home care in an intermediate care facility (ICF) or skilled nursing facility (SNF) certified as eligible to participate in the Tennessee Medicaid program.

[3]Medicaid is a joint state-federal funding program for medical assistance for the needy in which the federal government approves a state plan for the funding of medical services and then subsidizes a significant portion of the financial obligations the state has agreed to assume. Once a state chooses to participate in Medicaid, the state must comply with the statute's requirements, including regulations. *See Alexander v. Choate*, 469 U.S. 287, 289n.1 (1985). In Tennessee, the federal government funds approximately 70 percent of these obligations. Payments are made by the Health Care Financing Administration

a skilled nursing facility (SNF) could certify a distinct part of a facility (e.g., a wing, one side of a corridor, a floor) for Medicaid participation, for patients requiring a different level of care.[4] As part of distinct part certification, Tennessee allowed skilled nursing facilities, at their discretion, to "spot" certify beds for Medicaid participation. This practice allowed fewer than all beds within a particular wing or floor to be available for Medicaid recipients regardless of their required level of care. In addition, Tennessee allowed facilities to certify as Medicaid beds fewer than all beds available for residents residing in intermediate care facilities. These practices shall be referred to as the "limited bed policy." Twenty-three percent of Tennessee's Medicaid participating nursing homes chose to have Tennessee certify beds under the limited bed policy. Under this policy, seven percent of the total beds in Medicaid-participating facilities, which would otherwise have been certified, went uncertified.

Plaintiff, Mildred Linton, receives Medicaid assistance and is severely disabled from rheumatoid arthritis. At the time this lawsuit was commenced, she was receiving an [*sic*] SNF level of care at the Green Valley Health Care Center, a Tennessee nursing facility. In 1986, Medicaid officials, reviewing her medical record, determined that she no longer required such a high level of care and informed her that they were reducing her care eligibility to intermediate. Green Valley, under distinct part certification, had 87 intermediate care facility (ICF) beds. Under

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(HCFA) of the federal Department of Health and Human Services. The Tennessee Department of Health and Environment is responsible for administering Tennessee's Medicaid program.

[4]At the time this action was brought, facilities were classified as skilled nursing facilities or intermediate care facilities, depending on the degree of care provided, with the former involving a higher degree of care. In 1987, Congress eliminated these distinctions and created a single category of "nursing facilities," effective October 1, 1990. *See* 42 U.S.C. § 1396r(a).

Tennessee's limited bed policy, however, it had apportioned only 40 of those beds as ICF Medicaid beds. Green Valley informed Linton that it intended to decertify her Medicaid bed and, due to a considerable waiting list for ICF Medicaid beds, would not likely have available any ICF Medicaid beds.[5] The facility's action, as condoned under Tennessee's limited bed policy, would force Linton to leave the nursing home where she had lived for four years and which was located close to her family, with no assurance that a Medicaid bed would be available for her elsewhere.

Plaintiff-intervenor, Belle Carney, age 89 at the time this suit was filed, suffers from Alzheimer's disease. In 1987, she was hospitalized for two weeks and was to be discharged to a nursing home. Carney, who is eligible for Medicaid and is black, had difficulty finding a Medicaid bed. In the interim, she was shunted among a series of inadequate and unlicensed facilities.

Plaintiffs alleged under 42 U.S.C. § 1983 that Tennessee's limited bed policy violated the Medicaid Act. Plaintiffs raised several challenges under the Medicaid Act, including the claim that Tennessee's limited bed policy did not meet federal distinct part standards. They also alleged that the policy had a disparate impact on black class members in violation of Title VI of the Civil Rights Act of 1964, 42 U.S.C. § 2000d *et seq.* (Title VI), and its implementing regulations.

The district court, setting forth findings of fact and conclusions of law, pursuant to Fed. R. Civ. P. 52, found that Tennessee's limited bed policy violated distinct part certification standards and other provisions of the Medicaid Act. The court indicated that the purpose of distinct part certification was to accommodate the delivery of qualitatively different types of health

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[5]In contrast, at the time, private-paying ICF patients were allowed to compete for any ICF bed in a facility regardless of whether the bed was Medicaid-certified and thus had a shorter wait before placement in an ICF bed.

care within the same facility. Tennessee's limited bed policy, in contrast, served "the interests of nursing homes who wish to participate in the Medicaid program while also maintaining a separate private pay facility offering the same type of care." Violations of distinct part certification standards included certification even when a facility did not house all ICF residents in the certified portion of the institution. Moreover, Tennessee certified beds under distinct part standards even when no separately administered unit of a facility existed at all. HCFA in interpreting the distinct part certification provision had expressly advised that spot certification did not satisfy distinct part certification: "'Various beds scattered throughout the institution would not comprise a unit operated distinguishably'" for certification purposes. The court also found that the limited bed policy violated Title VI.

As a result of its liability determinations, the court instructed Tennessee to submit a remedial plan, including prophylactic measures to prevent or mitigate Medicaid provider attrition. Heightened attrition by Medicaid providers was of acute concern to the district court. Previously, the court had denied plaintiffs' request to enjoin preliminarily Tennessee's limited bed policy because the court found that granting relief would cause substantial harm to the plaintiffs: some providers would opt out of the Medicaid program and traumatize their Medicaid patients who, as a result of discontinuation of services, would be transferred away from families or discharged to inadequate alternative care. In response to the district court's instruction, Tennessee proposed a plan that it had negotiated with plaintiffs. The four-part remedial plan consisted of two introductory parts, followed by two substantive parts addressing the laws found to have been violated, the Medicaid Act and Title VI. The Medicaid Act remedies were included in Part III, entitled "Plan Regarding Distinct Part Certification." That part required Medicaid providers to certify all available, licensed nursing home beds within their facilities ("full certification") and to admit residents on a first-come, first-serve basis; prohibited involuntary transfer or discharge based upon source of payment; and adopted procedures for provider

withdrawal from the program, including patient protection and disincentives to discourage provider attrition. Providers who chose to withdraw from the system were required to retain current Medicaid patients and comply with Medicaid requirements as to such patients (the so-called "lock-in" requirement). Providers who withdrew would be excluded from Medicaid participation for two years after withdrawal (the so-called "lock-out" requirement). Part IV addressed Title VI violations and was entitled "Defendant's Plan to Redress the Finding of Unintended Disparate Impact on Minorities' Access to Nursing Homes." Its remedies included draft rules for Title VI civil rights compliance and enforcement, added staff to Tennessee's Office of Civil Rights Compliance, and incorporated by reference the measures adopted in Part III of the plan. The district court adopted the plan without amendment.

On July 30, 1990, 25 days after the district court had entered final judgment in this action, defendant-intervenors pursuant to Fed. R. Civ. P. 24 filed a motion to intervene for purposes of appeal. Defendant-intervenors are five licensed nursing homes in Tennessee. Only defendant-intervenor RHA/Sullivan, Inc., certified fewer than all of its patient beds under the Medicaid Act. The others certified all of their patient beds, however, they prefer private-paying residents over Medicaid recipients as patients, and therefore are impacted by the remedies adopted, including the lock-in provision. *See Linton v. Commissioner of Health & Env't*, 973 F.2d 1311, 1318 n.12 (6th Cir. 1992). Defendant-intervenors sought to intervene in this action because they want to allot beds occupied by Medicaid residents to non-Medicaid residents financially capable of paying higher occupancy rates. *See id.* at 1317. The distinct court denied their motion as untimely and determined they lacked standing.

On appeal, we reversed. *Id.* Plaintiffs and Tennessee then moved to modify the mandatory lock-in provision by replacing it with an optional one, which motion the court granted. In addition, the lock-out provision has been revised to allow the state to waive this provision when contracting with a former provider would otherwise serve the interests of the remedial plan. The district

court then granted defendant-intervenors' motion to intervene and docketed their notices of appeal *nunc pro tunc*.[6] Plaintiffs and Tennessee, however, moved to dismiss defendant-intervenors' appeal in light of the modifications made to the remedial plan. We denied that motion and held that defendant-intervenors could pursue appellate review of the remedial plan. *Linton v. Commissioner of Health & Env't*, 30 F.3d 55, 57 (6th Cir. 1994).

I.

In their appeal on the merits, defendant-intervenors raise two issues: (1) the district court's factual finding of disparate impact in violation of Title VI was clearly erroneous; and (2) the district court abused its discretion in granting the relief that it did.

Defendant-intervenors do not challenge the district court's findings regarding violations of the Medicaid Act and its implementing regulations. *See* defendant-intervenors' br. at 7 ("Although the district court found that both the Tennessee Certification Policy did not meet federal distinct part standards and made conclusory holdings with respect to a number of plaintiffs' other Medicaid Act claims ... only plaintiffs' Title VI claims -- and the relief the district court ordered with respect to those claims -- are at issue in this appeal.")

The district court's Medicaid Act rulings were the subject of previous litigation, however. The Tennessee Health Care Association (THCA), which participated as amicus curiae at the district court level in this case and which has obtained financing and legal assistance from the American Health Care Association and employed an attorney for the purpose of representing the defendant-intervenors, *see* 973 F.2d at 1316, brought a separate action under the medicaid Act against defendant, seeking to compel defendant to file the *Linton* remedial plan with the Health

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[6]One of the original intervenors, Brook Meade Health Care Center, Inc., was voluntarily dismissed by stipulation due to pending bankruptcy proceedings.

Care Financing Administration for HCFA's approval. *See* 42 C.F.R. § 430.12(c) (material changes in state policy must be submitted to HCFA for review).

On January 24, 1991, THCA received a letter from the regional administrator of HCFA Region IV, who is authorized to approve Medicaid state plan amendments. *See* 42 C.F.R. § 430.15(b). That letter stated that HCFA had reviewed the *Linton* plan and concluded that no formal state plan amendment was required and that the "*Linton* plan was consistent with federal requirements." *Tennessee Health Care Ass'n v. Commissioner, Tenn. Dep't of Health & Env't*, Nos. 91-5789; 91-6220, 1992 WL 36217, at *1 (6th Cir. Feb. 26, 1992). In light of this informal approval, THCA sought and was granted dismissal of its action with prejudice. *Id.*

Defendant-intervenors' appeal challenges the breadth of some of the remedies adopted by the court under Part III of the remedial plan. Rather than dispute the validity of the district court's determination that the Medicaid Act has been violated, however, defendant-intervenors only appeal the district court's disparate impact finding under Title VI as an improper predicate for these remedies. Defendant-intervenors do not claim, however, that no legal predicate exists for these remedies, rather, they simply argue that because the disparate impact finding under Title VI was erroneous, the "underlying legal predicate for the Court's actions would be *altered*." Defendant-intervenors' br. at 42 (emphasis added). It is beyond peradventure, however, that "if the judgment of the lower court is correct for any reason, it will be affirmed." *Paine & Williams Co. v. Baldwin Rubber Co.*, 113 F.2d 840, 844 (6th Cir. 1940). In this case, all of the remedies challenged on appeal appear in Part III of the plan. None of these remedies are predicated on a finding of a Title VI violation, alone. At most, they are all incorporated by reference within Part IV, which incorporates by reference Part III of the plan. Therefore, we consider whether the remaining unchallenged legal predicate for the remedies disputed on appeal, the Medicaid Act, is sufficient to

uphold the breadth of the remedies disputed on appeal. If so, we need not reach the merits of defendant-intervenors' challenge to the disparate impact finding, as it would have no bearing on the result sought by defendant-intervenors: to vacate the remedial plan and remand for narrower remedies for Medicaid Act violations imposed under Part III of the remedial plan.

A. The Remedial Plan

1. Conformance with the Medicaid Act

Defendant-intervenors argue that this court should vacate the remedial plan and remand this case because the district court abused its discretion by exceeding its authority in imposing an overbroad remedy. *See United States v. City of Parma*, 661 F.2d 562, 576 (6th Cir. 1981) ("courts must carefully tailor the remedy in cases of statutory violations, limiting it to relief necessary to correct the violations"), *cert. denied*, 456 U.S. 926 (1982). In *Parma*, we reviewed a remedial plan imposed by the district court for violations of the Fair Housing Act. In considering the plan, we addressed a district court's power to grant relief necessary to correct statutory violations:

> The breadth of the remedial order does not, in itself, indicate that a court has exceeded its authority. As Chief Justice Burger wrote for the Supreme Court in *Swann v. Charlotte-Mecklenburg Board of Education*, 402 U.S. 1, 15, 91 S.Ct. 1267, 1276, 28 L.Ed.2d 554 (1971):
>
> > Once a right and a violation have been shown, the scope of a district court's equitable powers to remedy past wrongs is broad, for breadth and flexibility are inherent in equitable remedies.
> >
> > > The essence of equity jurisdiction has been the power of the Chancellor to do equity and to mould each decree to the necessities of the particular case. Flexibility rather than rigidity has distinguished it.

> The qualities of mercy and practicality have made equity the instrument for nice adjustment and reconciliation between the public interest and private needs as well as between competing private claims [quoting *Hecht Co. v. Bowles*, 321 U.S. 321, 329-30 (1944)].

661 F.2d at 576.

We apply the same considerations here. Unlike the parties in *Parma*, however, plaintiffs and defendant in this case negotiated the remedy entered by the district court. In reviewing a consent remedy, we consider whether the remedy "conflicts with or violates the statute upon which the complaint was based" or violates the intervenors' constitutional rights. *See Local 93, International Ass'n of Firefighters v. City of Cleveland*, 478 U.S. 501, 526 (1986). A consent remedy, like a court-imposed remedy, is also reviewed for abuse of discretion. *Rufo v. Inmates of Suffolk County Jail*, 502 U.S. 367, 389 (1992). Under that standard, we must reverse if we are firmly convinced that a mistake has been made. *E.g., Miller's Bottled Gas, Inc. v. Borg-Warner Corp.*, 56 F.3d 726, 734 (6th Cir. 1995).

Defendant-intervenors do not dispute the validity of the remedial plan's full certification requirement as a remedy for the Medicaid Act violations found. They contend rather that the procedures adopted to implement that requirement are overbroad, challenging, specifically, the plan's requirements that (1) Medicaid providers adopt a "first-come, first-served admissions" policy with limited exceptions that no longer include an exception based on source of payment for services (i.e., preference for private-paying patients); (2) providers who opt out of Medicaid participation must continue to serve existing Medicaid patients in compliance with the Medicaid Act; (3) impose a two-year moratorium on future participation by those providers who have chosen to withdraw; and (4) require providers to notify patients that they are withdrawing.

a. First-Come, First-Serve Requirement

We initially address the propriety of the first-come, first-serve admission requirement. Defendant-intervenors, without more, claim that this requirement is overbroad. We disagree. The record shows there are more applicants than there are nursing facility beds. The first-come, first-serve policy limits preferences among applicants to those based on medical needs. Defendant-intervenors argue that the rule unnecessarily precludes an exception for private-pay preference. Such an exception would swallow the rule, however. Under such an exception, providers could provide even fewer beds for Medicaid patients than they did under the limited bed policy.

b. "Lock-in" Requirement

We next consider defendant-intervenors' attack on the plan's "lock-in" or continued service provision, which they contend violates the Medicaid Act. Under this provision, current Medicaid patients are allowed to remain in a nursing facility that chooses to withdraw from the Medicaid system. This provision was adopted as an interim measure to mitigate patient transfer trauma and to minimize involuntary transfer and discharge of Medicaid patients by providers withdrawing from the system. Defendant-intervenors contend that this feature impermissibly interferes with their business decision to favor higher paying private-pay patients and contravenes the voluntary nature of provider participation in Medicaid. The only statutory authority cited in support of their argument, however, is 42 U.S.C. § 1396a(a)(30)(A), which states that a state Medicaid plan must provide payments "sufficient to enlist enough providers so that care and services are available under the plan." That provision is irrelevant here as the adequacy of Medicaid reimbursements is not at issue in this case. The continued service provision merely addresses the availability of continued service for Medicaid residents in facilities that are withdrawing from the Medicaid system. It does not address the general availability of Medicaid providers.

A review of the Medicaid Act's provisions in pertinent part suggests that defendant-intervenors' argument is without merit. The Medicaid program through its contract system is predicated upon provider compliance with the Medicaid Act in exchange for compensation. Under the Act, "any individual eligible for medical assistance ... may obtain such assistance from any [provider] who undertakes to provide him such services." 42 U.S.C. § 1396a(a)(23). Regulation of such services includes prohibitions on improper transfers. *See* 42 U.S.C. § 1396r(c)(2)(A) (facilities must allow a resident to remain in the facility and may not transfer or discharge the resident from the facility unless the resident's needs cannot be met or the resident's health or safety is endangered, the resident has failed to make proper payments to the facility, or the "facility ceases to operate"). Even when a resident has failed to make payment, contractors must continue to provide care pending an opportunity for administrative review regarding funding. *See* 42 U.S.C. § 1396r(c)(2)(A)-(C). Tennessee regulations bar involuntary transfer of even non-paying patients when necessary to prevent "traumatic effect on the patient." Tenn. Dep't of Health and Env't R. 1200-8-6.02(7)(d).

Nowhere does the Medicaid Act permit involuntary transfer on the basis that facility chooses to withdraw from the Medicaid program because it thinks it can make more money serving private patients. A nursing facility is required to "establish and maintain identical policies and practices regarding transfer, discharge, and the provision of services required under the State plan for all individuals regardless of source of payment." 42 U.S.C. § 1396r(c)(4). Similarly, admission decisions may not be based upon eligibility or future eligibility under Medicaid. *See* 42 U.S.C. § 1396r(c)(5). As the district court recognized, full certification in undiluted form would likely prompt certain providers to withdraw from the Medicaid system. Thus we find the continued service provision is an appropriate interim measure to mitigate the harmful effect of that consequence and consistent

with the Medicaid Act.[7]

c. "Lock-Out" Requirement

We next address the propriety of the so called "lock-out" or moratorium provision. That provision dictates that Tennessee will not contract for a period of two years with facilities that have terminated their Medicaid agreements. Defendant-intervenors contend that this provision conflicts with 42 C.F.R. § 442.12, which provides for denial of provider participation for "good cause."[8] Defendant-intervenors further argue that, although the regulation does not define "good cause," we should construe the phrase as limited to fraud and abuse or failure to provide services as required by federal regulations. Section 442.12 is inapposite. That provision applies to certified facilities, Medicaid providers who are about to be involuntarily decertified. *See* 42 C.F.R. § 442.12(d)(1). The moratorium provision, by its very nature, only pertains to providers who have already withdrawn from the system, and now for their own reasons seek re-entry.[9]

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[7]As noted previously, the plan has been modified to make the mandatory "lock-in" provision voluntary.

[8]That provision provides that a state Medicaid plan must include that:

> (1) If the Medicaid agency has adequate documentation showing good cause, it may refuse to execute an agreement, or may cancel an agreement, with a certified facility.
>
> (2) A provider agreement is not a valid agreement for purposes of this part even though certified by the State survey agency, if the facility fails to meet the civil rights requirements set forth in 45 CFR Parts 80, 84, and 90.

42 C.F.R. § 442.12(d).

[9]Defendant-intervenors themselves do not argue that section 442.12 is controlling.

Ample reasons exist to justify the moratorium provision. Tennessee imposed the moratorium as a disincentive to providers from withdrawing. The record indicates that a provider's withdrawal from Medicaid can cause discharge trauma to Medicaid nursing home patients, particularly the frail elderly, who may be involuntarily transferred or discharged to facilities away from families or friends. Without this provision, contractors could engage in a de facto limited bed policy, albeit through a revolving door system: enrolling in the Medicaid system long enough to fill the limited capacity desired by the provider and then withdrawing once that capacity had been met (and reenrolling when the number of Medicaid beds fell below that self-set limit).

d. Notification of Withdrawal Requirement

Defendant-intervenors also challenge the notification of withdrawal requirement, which requires providers to inform Medicaid patients that the providers are withdrawing from the Medicaid system. This requirement is consistent, however, with the law requiring nursing facilities participating in the Medicaid program to apprise patients of their rights. *See* 42 U.S.C. § 1396r(c)(1)(B); 42 C.F.R. § 483.10(b); Tenn. Code Ann. § 68-11-804(c)(2); *id.* at § 68-11-910; Tenn. Dep't of Health and Env't R. 1200-8-6-.02(10)(a).[10]

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[10]Additionally, we find persuasive plaintiffs' argument that, regardless of this lawsuit, Tennessee had the authority under federal and state law to adopt the remedial measures at issue. For example, under the Act, Tennessee must provide "such safeguards as may be necessary to assure that eligibility for care and services under the plan will be determined, and such care and services will be provided, in a manner consistent with simplicity of administration and the best interests of the recipients." 42 U.S.C. § 1396a(a)(19). Considerable deference is provided to states under the Act to decide "eligible groups, types and range of services, payment levels for services, and administrative and operating procedures." 42 C.F.R. § 430.0. In 1987, Congress enacted a series of statutory reforms through the Omnibus Budget Reconciliation Act of 1987. These reforms created additional requirements for nursing facilities, *see generally* 42 U.S.C. § 1396r, including strengthening Medicaid patient rights, 42 U.S.C. § 1396r(c)(1)(A), notification to nursing facility residents of such rights, *id.* at

2. Impairment of Contract

In addition to disputing the plan's conformance with the Medicaid Act, defendant-intervenors also argue that the plan's continued service and moratorium provisions substantially impair defendant-intervenors' contractual relationship with Tennessee. *See* U.S. const. art. I, § 10, cl. 1 ("No State shall ... pass any ... Law impairing the Obligation of Contracts"). In evaluating a claim of contract impairment, the Supreme Court has adopted a three-prong test considering: (1) whether complainant has shown "a substantial impairment" of a contractual relationship; (2) assuming substantial impairment is shown, whether the state has a "significant and legitimate public purpose behind the regulation" alleged to impair the contract, such as the "remedying of a broad and general social or economic problem"; and (3) assuming a legitimate public purpose has been identified, whether adjustment of rights and responsibilities of contracting parties is based upon reasonable conditions and is of a character appropriate to the "public purpose" justifying the legislation's adoption. *Energy Reserves Group, Inc. v. Kansas Power & Light Co.*, 459 U.S. 400, 411-12 (1983). The restrictions of the Contract Clause must be reconciled with the "'essential attributes of sovereign power,'" which are necessarily reserved by the states to safeguard their citizens. *United States Trust Co. v. New Jersey*, 431 U.S. 1, 21 (1977) (quoting *Home Building & Loan Ass'n v. Blaisdell*, 290 U.S. 398, 435 (1934).

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§ 1396r(c)(1)(B), prohibitions relating to transfers and discharge of residents, *id.* at § 1396r(c)(2); permitting state access to residents for regulatory purposes; *id.* at § 1396r(c)(3); requiring equal access to care for residents "regardless of source of payment," *id.* at § 1396r(c)(4); and protections in admissions of Medicaid recipients, *id.* at § 1396r(c)(5). Moreover, HCFA reviewed and approved the plan. *See Tennessee Health Care Ass'n v. Commissioner, Tenn. Dep't of Health & Env't*, Nos. 91-5789; 91-6220, 1992 WL 36217, at *1 (6th Cir., Feb. 26, 1992). Particular deference is owed to HCFA as the agency in charge of implementing the Medicaid Act.

Applying this analysis, we first consider whether defendant-intervenors have shown a substantial impairment of their Medicaid contracts with Tennessee.[11] Defendant-intervenors claim that the impairment caused by the continued service provision is "substantial if not total." They contend that under that provision they are unable to exercise their contracts' termination clause, which allows them to terminate their Medicaid contract with Tennessee upon 30 days notice, thereby unduly interfering with their "fundamental right of contract termination." Additionally, they argue, the provision makes their agreements' one-year term provision meaningless, and they no longer have the ability to accept or reject changes in federal standards through revocation of the provider agreement. Therefore, they allege, they have lost the voluntariness of the contract. As for the moratorium provision, defendant-intervenors imply that they have been excluded from contracting with state of Tennessee for the business decision of terminating their contracts.

In addressing whether the continued service provision substantially impairs defendant-intervenors' contracts, we note that the sample contract on which defendant-intervenors rely was executed after final adoption of the *Linton* remedial plan. As a factual matter, therefore, no impairment could have taken place. *See, e.g., Oshkosh Waterworks Co. v. City of Oshkosh*, 187 U.S. 437, 446 (1903) (Contract Clause refers only to state action taken after the making of the contract whose obligation is alleged to have been impaired). As for any previous contracts that may have been in effect at the time that the continued service provision was adopted, we find that rather than undermine the benefit of the bargain of those contracts, the continued service provision gives providers who choose to withdraw from the system an enhanced version of the system in place before any remedy was adopted.

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[11]Although the actual contracts are not contained in the record, Tennessee, as a party to such contracts, in opposing defendant-intervenors' appeal, does not refute in its statement of facts or otherwise the existence of the contract language and provisions relied on by defendant-intervenors.

Under the continued service provision, these providers may continue to serve a limited number of Medicaid participants while reserving all additional beds for private-paying patients as they become available.[12] *See Energy Reserves Group*, 459 U.S. at 411 (state's restriction of a party to gains it reasonably expected from the contract does not necessarily constitute substantial impairment). The continued service provision does not obligate providers to bring in any more Medicaid patients; it merely curtails the impact of patient trauma caused by providers' decision to withdraw from the system.

The Supreme Court has recognized three components to the inquiry whether a change in state law has "'operated as a substantial impairment of a contractual relationship.'" *General Motors Corp. v. Romein*, 503 U.S. 181, 186 (1992) (quoting *Allied Structural Steel Co. v. Spannaus*, 438 U.S. 234, 244 (1978). These include whether (1) a contract exists, (2) a change in law impairs that contract, and (3) the impairment is substantial. 503 U.S. at 186. Defendant-intervenors in presenting their argument only address the third component of this inquiry. We find, however, that defendant-intervenors have failed to establish the first two components of the analysis and, therefore, their argument must fail. The sample contract upon which defendant-intervenors rely to establish the existence of their contracts was executed after final adoption of the *Linton* remedial plan. State action cannot impair a contract provision that did not exist at the time the state action occurred. *See id.* at 186-87 (no contractual agreement existed regarding workers' compensation terms at time of state action). As for any previous contracts that may have been in effect at the time that the continued service provision was adopted, defendant-intervenors have made no showing that they either desired or attempted to terminate those contracts.

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[12]Ironically, one of the defendant-intervenors, McKendree Village, Inc., sought and obtained a modification of the continued service rule to expand its protection to residents who became Medicaid-eligible only after McKendree Village had withdrawn from the Medicaid program.

We next address whether the moratorium provision impairs the contractual relationship between defendant-intervenors and Tennessee. The provision only affects providers who do not have contracts with Tennessee. In that sense, defendant-intervenors' use of the term "lock-out" is a misnomer. *Cf.* 42 C.F.R. § 431.54(f) (setting forth notice and opportunity to be heard requirements for participating providers to be locked out for abuse). In general, a state is free to contract with whom it pleases. *Perkins v. Lukens Steel Co.*, 310 U.S. 113, 127 (1940) ("Like private individuals and businesses, the Government enjoys the unrestricted power to ... determine those with whom it will deal"). Indeed, Medicaid law requires the state to contract with entities that are "qualified to perform the ... services required." 42 U.S.C. § 1396a(a)(23). A state does not have to enter into and may rescind a provider contract with an entity that fails to comply with federal law. *See* 42 C.F.R. § 442.12(d)(2).

Even if the continued service and moratorium provisions were to impair defendant-intervenors' contractual relationship with Tennessee, in determining whether such an impairment would be substantial, a court looks to the pervasiveness of the regulation of the industry at issue. *Energy Reserves Group*, 459 U.S. at 411 ("'When he purchased into an enterprise already regulated in the particular to which he now objects, he purchased subject to further legislation upon the same topic'") (quoting *Veix v. Sixth Ward Bldg. & Loan Ass'n*, 310 U.S. 32, 38 (1940). In this instance, the nursing home industry is a pervasively regulated industry. *See Clay County Manor, Inc. v. Tennessee*, 849 S.W.2d 755, 760 (Tenn, 1993). Defendant-intervenors participate in such an industry as Medicaid providers and were subject to pervasive regulation prior to the elimination of Tennessee's limited bed policy. The magistrate judge's report and recommendation of liability in this case, issued more than two years prior to the district court's adoption of that report and recommendation, in substantial part gave the defendant-intervenors, who acknowledge

notice of the pending litigation,[13] notice that changes in the law were likely. Indeed, a 1988 draft of the remedial plan, which was provided to THCA as amicus curiae, contained a version of the lock-in provision. *See* 973 F.2d at 1315. The defendant-intervenors notwithstanding this knowledge renewed their contracts.

Even if the provisions were to substantially impair defendant-intervenors' contracts, our inquiry would not stop there. We would still consider whether the remedial plan were based upon a significant and legitimate public purpose. *Energy Reserves Group*, 459 U.S. at 411 (state action that substantially impairs a contract can be justified in the presence of "a significant and legitimate public purpose.") Normally, we defer to a state's judgment as to the necessity of a measure in question, *United States Trust*, 431 U.S. at 22-23, however, when the state is a party to the contract at issue, we must discern whether under the circumstances the state's self-interest renders such deference inappropriate. *Id.* at 26. Defendant-intervenors characterize Tennessee's involvement in the remedial plan as based upon pecuniary self-interest. Without more, they accuse Tennessee of agreeing to the plan "as a self-serving means of satisfying the district court's desire to prevent provider attrition without having to increase payments to enlist more providers." Defendant-intervenors imply that the violations caused by the limited bed policy could have been remedied by increased payments to entice more providers. This argument, however, is unavailing. First, this was an action brought on behalf of Medicaid-eligible persons, not providers, against Tennessee in its regulatory capacity. The issues raised did not include the reasonableness of provider payments or the need for additional providers but, rather, the legitimacy of Tennessee's policy of certifying providers as Medicaid providers, while allowing nursing homes to limit artificially the available beds for

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[13]The facilities' state association, the THCA, participated as amicus curiae at the district court level in this case.

Medicaid patients.[14]

Moreover, any argument that Tennessee was motivated by a desire to avoid greater state expenditure is belied by Tennessee's actions in this case. The plan reveals that, although not an issue in the litigation, Tennessee increased its Medicaid nursing home reimbursement rates as part of its effort to mitigate provider attrition. The elimination of the limited bed policy in favor of a full certification policy itself seeks to increase the availability of Medicaid beds for Medicaid patients within the system, and thus increase Tennessee's financial obligation under Medicaid. In addition, the policies adopted to further that goal, such as the continued service provision, create further financial obligation on Tennessee by continuing Medicaid payments to providers who choose to withdraw from the system.

Defendant-intervenors characterize the continued service and moratorium provisions as "punitive rather than regulatory." Yet they concede that the provisions apply regardless of a provider's reason for withdrawal. Defendant-intervenors further contend that "if the remedial plan were truly designed to serve [its purpose], it would simply have forbidden withdrawing facilities from engaging in transfers or discharges without proper discharge planning ... rather than a blanket lock-in requirement." Defendant-intervenors' reply br. at 24. This argument seeks to substitute the defendant-intervenors' judgment for the judgment of the state of Tennessee, which judgment we have concluded is not motivated by self-interest and is therefore entitled to deference.

Lastly, we consider whether the plan properly adjusts the rights and responsibilities of the contracting parties. *See* 459 U.S.

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[14]Although we reversed the district court's denial of defendant-intervenors' motion to intervene, we note that the district court in ruling against the motion expressed its concern that the movants were seeking to convert the proceeding into an action challenging the reasonableness of provider payments. *See* 973 F.2d at 1319.

at 412. Tennessee has general rulemaking authority pursuant to Tenn. Code Ann. § 68-1-103, as well as authority to effectuate the purposes of Tenn. Code Ann. § 71-5-102-106, in implementing the Medicaid Act. Tenn. Code Ann. § 71-5-134. The provisions in the instant case respond to a district court's interpretation of Medicaid law and balance the interests of providers and patients, as third-party beneficiaries to such contracts. In particular, we note that the remedy did not force a provider to serve a single patient with whom it did not already have an existing patient relationship, or for whom the provider would not continue to receive a full Medicaid payment. Nor were these protections extended to any of the Medicaid-eligible patients on the withdrawing contractors' waiting lists.

B. Disparate Impact Finding

Because we find the remedial plan as disputed on appeal is adequately predicated upon the district court's unchallenged finding that Tennessee's limited bed policy violated the Medicaid Act, we need not address whether the district court erred in finding that the limited bed policy had a disparate impact on blacks.

AFFIRMED.

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IN THE UNITED STATES DISTRICT COURT FOR THE MIDDLE DISTRICT OF TENNESSEE, NASHVILLE DIVISION

MILDRED LEA LINTON, by her next friend KATHY ARNOLD, on her own behalf and on behalf of all other persons similarly situated,	)	
Plaintiff,	)	
BELLE CARNEY, by her next friend MARY KIMBLE, on her own behalf and on behalf of all other persons similarly situated,	)	CIVIL ACTION NO. 3-87-0941 JUDGE NIXON
Plaintiff-Intervenor,	)	
v.	)	
COMMISSIONER OF HEALTH AND ENVIRONMENT, STATE OF TENNESSEE	)	
Defendant.	)	

FINAL ORDER

This cause came on to be heard for a hearing on June 4, 1990, upon this Court's order of April 23, 1990, finding Tennessee's distinct part certification procedures to violate federal law and to occasion disparate impact upon minorities' access to nursing home care. In that order, the state defendant was directed to appear at a hearing to address remedies, and to submit a plan to address the disparate impact issue.

At the conclusion of the hearing, this Court found the state's

submission to be reasonably calculated to respond to the Court's April 23rd findings and to contain appropriate measures to mitigate Medicaid provider attrition. This finding is premised upon consideration of the submission; arguments and comments of counsel and those present at the hearing, including plaintiffs' lack of objection; and the record as a whole.

IT IS THEREFORE ORDERED that the state's submission is adopted in its entirety and is incorporated by reference in this final order in the cause. This Court has also approved an agreed order of the parties dismissing the due process and § 504, Rehabilitation Act claims.

This 5th day of July, 1990.

/S/
JOHN T. NIXON, JUDGE

IN THE UNITED STATES DISTRICT COURT FOR THE MIDDLE DISTRICT OF TENNESSEE, NASHVILLE DIVISION

MILDRED LEA LINTON, by her next friend KATHY ARNOLD, on her own behalf and on behalf of all other persons similarly situated,	)	
Plaintiff,	)	
BELLE CARNEY, by her next friend MARY KIMBLE, on her own behalf and on behalf of all other persons similarly situated,	)	CIVIL ACTION NO. 3-87-0941 JUDGE NIXON
Plaintiff-Intervenor,	)	
v.	)	
COMMISSIONER OF HEALTH AND ENVIRONMENT, STATE OF TENNESSEE	)	
Defendant.	)	

STATE SUBMISSION PURSUANT TO ORDER

I. INTRODUCTION

By memorandum and order entered on April 23, 1990, this Court determined that Tennessee's policy of allowing Medicaid participating nursing homes to certify less than all available beds for Medicaid participation was contrary to federal law, created a disparate impact upon minority Medicaid patients, and violated federal statutory Medicaid requirements. This Court ordered a hearing to be held on June 4, 1990, to determine an appropriate

remedy and further ordered the defendant to submit a plan for Court approval to redress the disparate impact upon minority Medicaid patients' access to qualified nursing home care.

While the state defendant denies that state officials have intentionally administered the Tennessee Medicaid program in a manner that discriminates against minorities, this submission contains plans to redress all aspects of the Court's findings. In view of the findings of unintentional rather than intentional discrimination, the defendant has reviewed and modified facially neutral procedures related to distinct part certification and formulated rules and policies intended to prevent further unintentional disparate impact upon minorities or Medicaid recipients. Counsel for plaintiffs has authorized the defendant to state that this plan is the product of the parties' negotiations and that plaintiffs' counsel concludes the plan is reasonably calculated to respond to the Court's findings and to ensure the Department's future compliance as to the issues of this lawsuit. The parties agree that immediate implementation of the plan is in the best interest of both parties.[1]

This submission contains a two part compliance plan, set forth at III and IV; reservation of future modification of the plan, at II; and exhibits containing draft rules and procedures, notices, letters and enforcement strategies.[2] See Collective Exhibits A, B, C and D. It is the intent of the parties to continue to discuss the state's management of the implementation and to provide the state flexibility in that process so long as it remains consistent with this plan.

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[1]In the event this plan is not adopted in its entirety or is modified in any respect, the state reserves its right to appeal issues previously raised as well as remedies imposed.

[2]The proposed rules and regulations and notices are subject to modification so long as they remain consistent with this plan and federal and state law.

Section III addresses distinct part certification, including prophylactic measures to prevent or mitigate provider attrition. Section IV redresses the finding of disparate impact upon minority Medicaid patients' access to nursing home care.

II. RESERVATION OF FUTURE MODIFICATION OF PLAN.

Subsequent Federal or State Law

The defendant reserves the right to modify the compliance plan as necessary to comply with federal and state law such as implementation of the federal Nursing Home Reform Act of 1987, Omnibus Budget Reconciliation Act of 1987 ("OBRA'87"), 42 U.S.C. § 1396r. Some relevant requirements of OBRA'87 will not become effective until October 1, 1990. In addition, specific guidance from the federal Health Care Financing Administration ("HCFA") to assist states in implementing OBRA'87 has not yet been promulgated and is not expected to be promulgated until September, 1990. OBRA'87 made numerous significant changes in requirements for Medicaid nursing facilities. The most significant change directly impacting upon this case is the elimination of distinctions between skilled and intermediate levels of care. After October 1, 1990, a person admitted to a nursing home is classified as a "resident" of the facility rather than being a patient in a skilled or intermediate portion of that facility. The new law permits facilities to retain a "distinct part" option, but "distinct part" is not defined therein. See 42 U.S.C. § 1396r(a).

Controlling law clearly establishes that prospective application of judgments must defer to a later change in the governing law in the case. See, e.g., Pennsylvania v. Wheeling and Belmont Bridge Company, 18 How. 421, 15 L.Ed.2d 435 (1855) and System Federation No. 91, Railroad Employees Department v. Wright, 364 U.S. 642, 51 L.Ed.2d 349, 81 S.Ct. 368 (1961). Such change in law includes modification of controlling federal regulations, Class v. Norton, 507 F.2d 1058, 1062 (2nd Cir. 1974); Williams v. Atkins, 786 F.2d 457, 461-62 (1st Cir. 1986);

Williams v. Butz, 843 F.2d 1335 (11th Cir. 1988). Regulations under the Medicaid Act have the force and effect of law. See, e.g., Smith v. Miller, 665 F.2d 172 (7th Cir. 1981); Planned Parenthood Affiliates v. Rhodes, 477 F. Supp. 529 (D.C. Ohio 1979); and Massachusetts General Hospital v. Sargent, 397 F. Supp. 1056 (D.C. Mass. 1975). Thus, the State may seek modification under Rule 60, Fed. R. Civ. P., to the extent necessary to accommodate subsequent law changes.

HCFA CONSULTATION

In accordance with this Court's order, the parties, by joint letter, have apprised the Regional Director of the U.S. Department of Health and Human Services ("H.H.S.") of the instant plan with reference to both the Medicaid and Title VI requirements. See Exhibit C. The defendant reserves the right to seek to modify the plan in light of any directives HCFA may provide.[3]

III. PLAN REGARDING DISTINCT PART CERTIFICATION.

A. Background

This Court's April 23rd memorandum and order required a further hearing to determine an appropriate remedy as to the distinct part certification findings and directed that prophylactic steps would be considered to prevent or mitigate provider attrition. See memorandum at 19, 25.

The state defendant has formulated the present plan

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[3]This plan reflects the position of the State, which intends to implement it as written, upon judicial approval. In the event of unanticipated H.H.S. objections, the State will seek to implement this plan and reserves the right to seek joinder of responsible federal officials, which does not foreclose use of other necessary administrative or judicial remedies.

regarding distinct part certification to address overall remedies, including system incentives and disincentives to prevent or reduce provider attrition. In summary, this plan:

1. requires certification of all available licensed nursing home beds in facilities that participate in Medicaid;

2. prohibits involuntary transfer or discharge based upon source of payment;

3. imposes admissions practices to regulate and enforce full certification and first come, first served requirements;

4. establishes procedures for orderly provider withdrawal from the program, including patient protection and incentives to reduce such attrition; and

5. includes draft policies, enforcement strategies and notification procedures.

As to provider attrition, the department has recently substantially enhanced Medicaid nursing home reimbursement. While adequacy of reimbursement rates are not an issue in this case and the state believes its current rates are adequate, payment rates will soon be capped at the 65th percentile rather than the 50th percentile, and calculation methods have changed, raising rates by approximately $9.00 from an estimated $41.89 to approximately $51.00 per day, per patient. That financial incentive is coupled with procedural disincentives in the plan including:

1. notification requirements;

2. duty to retain patients and comply with Medicaid requirements under specified circumstances; and

3. exclusion from the Medicaid program for at least two years after withdrawal.

B. Certification of All Beds

1. Effective immediately upon judicial approval of this plan, the Department will certify all available licensed nursing home beds for Medicaid participation in all nursing homes participating in Medicaid (hereinafter "facilities").

   a. Facilities which offer nursing home services only at the skilled level of care (SNF) will have all licensed beds certified for Medicaid participation at the SNF level.

   b. Facilities which offer nursing home services only at the intermediate level of care (ICF) will have all licensed beds certified for Medicaid participation at the ICF level.

   c. Facilities which offer nursing home services at both the SNF and ICF levels of care will have all SNF beds dually certified, that is, certified for both SNF and ICF participation. All other licensed nursing home beds will be certified as ICF only.

   This plan does not preclude a distinct part which has been certified by the Department as meeting all regulatory requirements, including the Linton requirements, such as a distinct part SNF which is located in a hospital or an ICF distinct part in a residential home for the aged. It is recognized that OBRA'87 requirements will eliminate the distinctions between SNF and ICF care as of October, 1990.

C. Transfer and Discharge

1. Immediately upon judicial approval of this plan, no resident will be involuntarily transferred or discharged from a Medicaid participating nursing facility because

their source of payment is Medicaid.

a. Residents who are currently paying for nursing home care with non-Medicaid funds and who exhaust those resources shall be encouraged to and entitled to apply for Medicaid. No resident may be transferred or discharged involuntarily because their source of payment has changed to Medicaid.

b. Effective upon judicial approval of this plan, residents who are Medicaid eligible as of June 1, 1990, but who are in facilities that have not sought Medicaid reimbursement for that resident because a Medicaid certified bed had not been available will not be required to pay any more than the resident's liability as determined by the Department of Human Services (e.g., social security, VA, Champus benefits, etc.). The facility will be required to make residents aware that it cannot transfer the residents because their source of payment has changed to Medicaid and will be required to encourage and assist all residents to apply for Medicaid. A Medicaid eligible resident is one who has an approved Pre-Admission Evaluation ("PAE") and has been determined to be financially eligible by the Department of Human Services. A resident whose PAE has been denied shall be considered Medicaid eligible until the exhaustion of their Medicaid appeals consistent with Doe v. Word, No. 3-84-1260 (M.D. Tenn.).[4]

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[4]It is the parties' intent to incorporate the requirement of Doe v. Word, Id., that a nursing home may not discharge a resident who is appealing a denial of a PAE until there has been a final denial of the PAE and any appeal that is pursued has been exhausted. Compliance with Doe, however, is not the subject of this lawsuit.

c. All residents who are determined to be financially eligible for Medicaid participation by the Department of Human Services as of June 1, 1990, but who have not submitted a PAE, or who have applied and not been finally denied, will also pay no more than the resident's liability as determined by DHS, until a PAE is denied and their appeals have been exhausted under Doe v. Word, Id.

2. Immediately upon judicial approval of this plan, residents receiving SNF services in nursing facilities which offer both SNF and ICF nursing home services may not be discharged involuntarily because the level of care for the resident changes to ICF.

3. An involuntary transfer or discharge of a resident inconsistent with the requirements of this section shall be considered an unlawful involuntary discharge under state and federal laws and regulations prohibiting such discharge and subject to all penalties and disciplinary actions pursuant thereto.

4. Residents shall be notified by the nursing home of transfer and discharge policies upon admission to the nursing home by means of the Resident Rights and Responsibilities form required by OBRA'87. This form also includes a notice of the resident's right to appeal an involuntary transfer and shall be in compliance with the attached notice. All notices required in this plan shall be issued to the residents and their designated representative. See Collective Exhibit A.

D. Admission Practices

1. All nursing facilities participating in Medicaid must admit residents on a first come, first served basis in accordance with the terms of this plan and the Department's rules.

a. (i) Effective immediately upon judicial approval of this plan, each nursing facility shall maintain a single waiting list for applicants. Such list will contain sufficient information to identify the applicant and for the state to monitor compliance with the plan.

(ii) For the purposes of this plan, the term "applicant" means any person who seeks admission to nursing home care. The use of the term is not limited to those persons who have completed an official application or have complied with the nursing home's pre-admission requirements, but it includes all persons who have affirmatively expressed an intent to be considered for current or future admission to the nursing home or requested that their name be entered on any waiting list. "Applicant" does not include those persons who make only a casual inquiry concerning the nursing home or its admission practices, who request information on these subjects, and who do not express any intention that they wish to be actively considered for admission.

b. Any person contacting a nursing home to casually inquire concerning its services or admissions policies shall be informed by the facility of his or her right to apply and be considered on a non-discriminatory basis in accordance with the policies and procedures set out herein. Brochures, admission forms and similar written materials used by a facility to market its services or describe its admissions policies shall contain a similar notice of applicant rights as provided herein. Pursuant to T.C.A. § 68-11-910(a)(5), such notice shall also inform the inquirer or applicant of the complaint and advocacy services available to him in the event that he believes his rights have been violated. The same notice shall be incorporated into the notices

required by T.C.A. § 68-11-910(b). (See Collective Exhibit A).

2. The nursing facility must admit applicants in the order in which the referral or request was received by the facility. Deviations from this principle shall be documented and may only be based upon the following exceptions:

   a. medical need, including but not limited to, the expedited admission of patients being discharged from hospitals, and patients who previously resided in a nursing home at a different level of care, but who, in either case, continue to require institutional medical services;

   b. the applicant's sex, if the only available bed is in a room or a part of the nursing home that exclusively serves residents of the opposite sex;

   c. as necessary to implement the provisions of a plan of affirmative action to admit racial minorities, if the plan has previously been approved by the Department;

   d. emergency placements requested by the Department when evacuating another health care facility or by the Adult Protective Services of the Department of Human Services;

   e. where a Medicaid-eligible resident's hospitalization or therapeutic leave exceeds the period paid for under the Tennessee Medicaid program for the holding of a bed in the facility for the resident and if the resident continues to require the services provided by the nursing home, then the resident must be readmitted to the facility immediately upon the first availability of a bed in the facility;

   f. other reasons or policies, e.g., community-based

waiver or care approved in advance in writing by the Medical director of the Department's Bureau of Manpower and Facilities; provided, however, that no such approval shall be granted if to do so would in any way impair the Department's or the facility's ability to comply with its obligations under federal and state civil rights laws, regulations or conditions of licensure or participation; or

g. where, with the participation and approval of the Department, expedited admission is approved for residents who are being displaced from another facility or its waiting list as a result of that facility's withdrawal from the Medicaid program.

3. If an applicant, whether on his or her own behalf or acting through another, requests admission or to be placed on a list of applicants awaiting admission, the information on the waiting list must be recorded and preserved.

E. **Facilities Requesting Voluntary Termination of Provider Agreements**

1. Facilities who choose to voluntarily terminate their provider agreement may do so by notifying the Department in writing of such intent. The effective date of the termination will be determined by the Department consistent with this plan. The facility's notice to the Department will provide the following information:

a. the reasons for voluntary termination;

b. the names and Medicaid identification number of all Medicaid-eligible residents;

c. a copy of a letter which shall conform with Collective Exhibit A and which will be sent to all residents explaining the facility's voluntary termination, and a

copy of a letter to be sent to all Medicaid-eligible residents explaining the facility's voluntary termination;

d. a copy of a letter which shall conform with Collective Exhibit A and which will be sent to all persons on the waiting list explaining the voluntary termination; and

e. other information determined by the Department as necessary to process the request for termination.

2. The termination of the provider's involvement in Medicaid must be done in such a manner so as to minimize the harm to current residents.

a. Residents who are currently Medicaid-eligible shall be informed, in a notice to be provided by the facility and approved by the Department, that the facility has elected to withdraw from the Medicaid program. The notice shall inform the resident of her right to remain in the facility as a Medicaid patient as long as she wishes to do so and remains otherwise eligible under the rules of the Medicaid program. The notice shall also inform the resident that, if she wishes to transfer to another facility, under the supervision of the Department, the nursing home where she now resides will assist in locating a new placement and providing orientation and preparation for the transfer, in accordance with 42 U.S.C. § 1396r(c)(2)(C), and any implementing regulations and guidelines.

b. All other residents of the facility shall receive a separate notice informing them of the facility's intention to withdraw from the Medicaid program. The notice will be provided by the facility after having been first reviewed and approved by the Department. The notice shall inform such residents that, should they become eligible for Medicaid coverage, they will

be able to convert to Medicaid from their current source of payment and remain in the facility only during a period that ends June 30, 1991. They will not be eligible for Medicaid coverage of their care in the facility thereafter.

The same notice will caution these residents that, if they require care as Medicaid patients beyond June 30, 1991, they will have to transfer to another facility. The notice will also inform the residents that, when their present facility is no longer participating in the Medicaid program, certain legal rights and protections that apply to all residents (regardless of source of payment) in Medicaid facilities will no longer be available to those who remain in the nursing home.[5] Readers of the notice will be informed that, if they wish to transfer, or to have their names placed on waiting lists at other facilities, the nursing home that is withdrawing from the program will assist them by providing preparation and orientation, under the supervision of the Department, as required by 42 U.S.C. § 1396r(c)(2)(C), and any implementing regulations and guidelines.

c. Applicants whose names are on the facility's waiting list will be notified by the facility, on a form that has been reviewed and approved by the Department, that the facility intends to withdraw from the Medicaid program. They will be cautioned that they will not be able to obtain Medicaid coverage for any care that they receive in the facility. The notice shall also inform them that certain legal rights and protections that apply to all residents (regardless of source of

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[5]Licensed only nursing homes must continue to comply with all federal and state laws and rules and regulations applicable to licensed only facilities.

payment) in Medicaid-participating facilities will not be available in the nursing home to which they have applied, once that facility has withdrawn from the Medicaid program.[6]

Applicants will be informed in the notice that, if they wish to make application at other facilities, the withdrawing facility, under the supervision of the Department, shall assist them in seeking placement elsewhere.

3. As long as a nursing home has a Medicaid-eligible resident, it must comply with all requirements for Medicaid participation. The facility will not, however, be entitled to payment for any additional or newly admitted Medicaid eligible residents under any circumstances.

4. After June 30, 1991, or the date on which the last resident who was Medicaid-eligible as of June 30, 1990, under ¶ III (E)(2)(a) is lawfully and appropriately transferred or discharged, whichever event occurs later, the nursing facility will be decertified and its Medicaid provider agreement terminated. Such transfers shall be considered an involuntary transfer and shall comply with Department rules and regulations governing involuntary transfers or discharges.

5. Facilities which terminate their provider agreements shall not be permitted to participate in Medicaid for a period of at least two years from the date the provider agreement is terminated.

6. Unless the facility notifies the Department within 30 days after giving a notice of termination, the facility may not stop the termination procedure consistent with this order

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[6]See footnote 5 above.

without written approval from the Department.

F. Policies and Procedures

All nursing homes will be required to establish policies and procedures addressing admission, transfer and discharge, consistent with this plan and rules of the Department. See Collective Exhibit B.

G. Enforcement Strategy

1. A nursing home which violates this plan or facility policies and procedures adopted pursuant thereto shall be subject to civil monetary penalties as provided by state law, suspension of admissions or other licensure disciplinary action, imposition of temporary management, imposition of a monitor (which may include a monitor of the admission process), and/or involuntary termination from Medicaid, and/or any other remedy available under the law.

2. Involuntary Termination -- a facility which is involuntarily decertified because of its failure to comply with the provisions of the Court Order and plans submitted thereto, shall not be permitted to participate in Medicaid for a period of five years.

H. Notification

1. All facilities shall post in a conspicuous location a poster notification prepared by the Department which describes applicants' and residents' rights consistent with this plan. (See Collective Exhibit A).

2. Any nursing home which, from June 1, 1988, through June 1, 1990, discharged or transferred residents because a Medicaid certified bed was not available or offered must notify such persons or their representative that the facility

no longer has such a policy and that it admits persons on a first come, first served basis regardless of the source of payment. See Collective Exhibit A.

3. The Department shall prepare a press release for distribution to the wire services concerning this plan and rights of applicants and residents pursuant thereto.

IV. DEFENDANT'S PLAN TO REDRESS THE FINDING OF UNINTENDED DISPARATE IMPACT ON MINORITIES' ACCESS TO NURSING HOMES.

A. Background

Since the original filing of this lawsuit, the Department of Health and Environment ("DHE") has made numerous administrative enhancements to increase enforcement of Title VI compliance. Those enhancements include:

1. The Office of Civil Rights Compliance ("OCRC"), which is part of the Bureau of Manpower and Facilities of the Department, developed draft rules for Title VI civil rights compliance and enforcement which are expected to improve elderly minority residents' access to nursing home services. A copy of the draft regulations, Chapter 1200-8-16, is attached as Collective Exhibit B.

2. In July, 1988, the DHE initiated and funded a local community referral project in Shelby County, known as the Minority Applicant Pool System ("MAPS"), to identify and place elderly minority individuals in appropriate nursing home facilities. The MAPS project is administered by the Delta Commission on Aging in cooperation with the Memphis Regional Health Center ("the Med").

3. In December, 1988, four staff positions were added to the office of Civil Rights Compliance, including three

Regional Coordinators (Health Facilities Surveyors) and one office clerk. The staff, as mandated by state law, is responsible for conducting periodic compliance reviews and investigating complaints on the 1,040 health care facilities licensed under the authority of the Board for Licensing Health Care Facilities. It is the Department's policy to conduct annual reviews on all nursing homes. All (approximately 290) nursing homes were reviewed by OCRC in 1989 either through a desk or on-site review.

B. Compliance Plan and Remedies

Consistent with prior United States Supreme Court holdings, this Title VI plan involves initial use of racially neutral practices, i.e. full certification of all nursing home facilities and enforcement of a neutral policy of a first come, first-served single waiting list. In view of this Court's finding of disparate impact on minorities' access to nursing home care as a result of admission practices, and in order to remedy such disparate impact, however, subsequent steps, if they become necessary, involve race conscious remedies. The first such remedies are premised upon the state's Method of Administration Plan, approved by the Office of Civil Rights Compliance of the Department of Health and Human Services as part of the Title VI compliance regulations under 45 C.F.R. Part 80. Those intermediate steps focus upon voluntary procedures to enhance minorities' access to nursing home care. They include, inter alia, creation of an identified pool of minorities eligible to be placed on the racially neutral first come, first served waiting lists; enhancement of such referrals through community outreach; development of and implementation of Title VI public service announcements and conducting education programs for nursing home staff.

Only after non-compliance of long duration will race preferential procedures, i.e. preferential admissions, be used. Thus, only a limited portion of the plan, narrowly tailored to deal with non-compliance of long duration, authorizes use of

race preferential procedures, consistent with the dictates of Wygant v. Jackson Board of Education, 106 S.Ct. 1842, 1847, 1850, 476 U.S. 275, 274, 90 L.Ed.2d 260 (1986), and cases cited therein; Hazelwood School District v. United States, 433 U.S. 299, 97 S.Ct. 2736, 53 L.Ed.2d 768 (1977); Fullilove v. Klutznick, 448 U.S. 448, 491, 100 S.Ct. 2758, 2781, 65 L.Ed.2d 902 (1980). See also, Local 28 of Sheet Metal Workers International Association v. Equal Employment Opportunity Commission, 106 S.Ct. 3019, 478 U.S. 421, 92 S.Ct. 344 (1986). Consistent with Supreme Court rulings, it is intended such remedies will be of temporary duration until compliance is achieved.

1. Full certification ("first come, first serve")

Section III's requirement of full certification is expected to increase utilization of beds by Medicaid recipients and, as a result, to increase utilization by Medicaid minorities.

2. Execution of Assurances of Compliance by Organizations with Multiple Facilities.

Any entity with two or more nursing home facilities in Tennessee will be required to execute an Assurance of Compliance with Title VI and comply with Title VI federal and state rules and regulations as to all of its Tennessee nursing homes if any of its nursing homes receive Medicaid funds.

3. Expansion of MAPS

The Department is committed to expanding the Minority Applicant Pool System ("MAPS") concept, currently in operation in Shelby County, to provide a MAPS approach in each of the four metropolitan areas. See ¶ 2, p. 5, infra. Development of MAPS in Shelby County required approximately three years. It is

anticipated MAPS can be in place in the other three metropolitan areas within approximately three years. That system is designed to identify and refer for placement elderly minority individuals in appropriate nursing home facilities.

The Department will explore the feasibility of expanding the MAPS concept statewide through development of specific local service delivery areas. Because rural areas lack the service network available in metropolitan areas, feasibility studies are required.

4. Monitoring of Minority Utilization

(a) Consistent with the Methods of Administration Plan of the Department, approved by the Department of Health and Human Services Office for Civil Rights, each year every Tennessee nursing home is required to complete a questionnaire reporting minority utilization in the facility, among other items pertaining to civil rights compliance. The percentage of minority residents in the nursing home will be compared to the percentage of minority citizens who are age 65 or older in the county in which the home is located by calculating the difference between the two factors. This computation is illustrated in the following example:

X Health Care Center, which has 100 licensed beds, reports that it had 12 black residents on the date of its report, a day when all beds were occupied. Thus, black residents constitute 12% of its census. X Health Care Center is located in Y county, Tennessee, for which the Department's Center for Health Statistics projects a 1988 population of 10,000 residents age 65 or older, of whom 1,500 are black. Thus, Y county has a 15% black population, age 65 or older. The

difference between these two factors is minus 3% (12% in nursing homes contrasted to 15% in the county), identifying a slight under-representation of black residents in X Health care Center (3 out of 100 patients under representation).

(b) A finding that a nursing home whose reported census of black residents is 10 percentage points (10%) or more below the percentage of black citizens age 65 or older in the county or service area in which the facility is located, according to the above calculation, will raise an inference of non-compliance with this plan. Such finding will trigger an evaluation and follow-up by the Office of Civil Right's Compliance according to the Department's Method of Administration Plan, as approved by the Office of Civil Rights of the United States Department of Health and Human Services. The facility will then be required to develop and implement affirmative action plans to improve access of racial minorities to the facility's services.

5. Affirmative Action Plans

(a) A nursing home may be found to be out of civil rights compliance through application of the above statistical standard coupled with an evaluation according to the Method of Administration Plan, through the resolution of a complaint investigation, based upon provisions of a judicial decree, based upon an evaluation, through findings of an administrative agency with jurisdiction over such matters other than the Department, or through other procedures authorized by law. Whenever such non-compliance is found, the nursing home will be required to prepare and submit for the Department's approval a plan of affirmative action, consistent with the Department's Methods of Administration Plan. Once approved, such plan shall

be implemented by the nursing home under the supervision of the Department. A finding of compliance by the Department's Office of Civil Rights Compliance may include but is not limited to reliance upon absence of statistical disparity as set forth herein.

(b) In developing the required affirmative action plans, non-compliant nursing homes will be encouraged to develop innovative plans individualized to the facility and its particular service area. The scope and duration of such plans will be determined by the Department's Office of Civil Rights Compliance director, and may include the following actions which are intended to improve access by racial minorities:

(i) enhancement of referrals through community interaction such as outreach to social services agencies, churches, civic groups, elderly apartments, hospital discharge planners, and similar entities,

(ii) development and implementation of Title VI public announcements for local media,

(iii) conducting on-site Title VI training for that facility's key staff, including the administrator, as determined by the Department and with the supervision and technical assistance of the Title VI staff; and/or

(iv) coordination or development of MAPS resources in counties in which no MAPS is available.

Subject to no objection being raised by HCFA, an additional affirmative action requirement may be imposed for entities with two or more nursing facilities in Tennessee where one of the facilities does

not participate in Medicaid and it has been found to not comply with Title VI. After a period of one year of operating under an approved affirmative action plan, if non-compliance continues, the Director of Civil Rights Compliance shall impose a requirement of deviating from the first come, first served waiting list to increase minority participation. Such requirement may include alternating admissions by race with a limitation upon admissions if no minority applicant is available. In lieu of that requirement, the non-compliant facility may opt to enroll in the Medicaid program, to be accomplished within three months of exercising that option.

(c) Other activities may be mandatory under the Methods of Administration Plan. Participation in MAPS is mandatory if a non-compliant facility is located within a MAPS service area.

C. Enforcement

In the event a facility fails to develop or implement an affirmative action plan or non-compliance continues after corrective action plans have been attempted, the matter will be referred to the Office of General Counsel for enforcement action. This Compliance Plan shall not, however, preclude enforcement by the Department or protected persons through other procedures authorized by law or rule. Enforcement may include seeking denial, suspension or revocation of a facility's license pursuant to T.C.A. § 68-1-218, Chapter 1200-8-16-.02, Rules of the Department of Health and Environment; imposition of civil penalties where applicable pursuant to T.C.A. §§ 68-1-218, 68-11-801, et seq.; requirement of temporary management; termination of a provider agreement; or any other sanction authorized by law, including termination of federal financial participation under the procedures set forth at 42 C.F.R. § 80.8(c).

D. Reports to the Court

On October 1, 1990, and on a quarterly basis for two years thereafter, the defendant shall file with the Court and serve on plaintiffs' counsel a report on the implementation of this plan. For one year thereafter, the same information shall continue to be compiled and provided upon request to plaintiffs' counsel, but need not be routinely filed with the Court. The reports required by this paragraph shall include the following information:

a. the name, address and Medicaid provider number of each facility that is licensed to provide nursing home care in the state, but which is not participating in the Medicaid program;

b. the identity of the owners of each such non-participating facility;

c. the number of licensed beds in each such facility, broken down (if applicable) by the type of care provided;

d. if the facility has given notice after June 1, 1990, of an intent to withdraw from the Medicaid program, the date on which such notice was received by the Department;

e. if a facility has given notice since June 1, 1990, of an intent to withdraw from the Medicaid program, the report shall state the number of Medicaid patients remaining in the facility as of the date the report is prepared; and

f. if the Department has any information regarding the facility's receipt of federal funds (either directly, or as part of a larger entity) the report shall identify the source of each different type of such federal funds.

After the initial report due to be filed by October 1, 1990, subsequent reports need only update the initial report as

necessary to reflect intervening changes. It is not necessary for subsequent reports to reiterate information contained in the original report regarding circumstances which remain unchanged.

E. Court Approval

Upon judicial approval, this submission shall become a final order.

Respectfully submitted,

CHARLES W. BURSON
Attorney General and Reporter

/S/
JENNIFER HELTON SMALL
Deputy Attorney General
450 James Robertson Parkway
Nashville, Tennessee 37243-0485
(615) 741-2640

Attorney for State Defendant

CERTIFICATE OF SERVICE

I hereby certify that a true and exact copy of the foregoing document has been forwarded by first-class U.S. Mail, postage prepaid, to Mr. Gordon Bonnyman, Attorney for Plaintiffs, Legal Services of Middle Tennessee, 800 Stahlman Building, 211 Union Street, Nashville, Tennessee 37201, on this 1st day of June, 1990.

/S/
JENNIFER HELTON SMALL
Deputy Attorney General

Collective Appendix A

STATE OF TENNESSEE
DEPARTMENT OF HEALTH AND ENVIRONMENT
CORDELL HULL BUILDING
NASHVILLE, TENNESSEE 37219-5402

NED McWHERTER
GOVERNOR

J. W. LUNA
COMMISSIONER

MEMORANDUM

DATE: June 4, 1990

TO: All Nursing Home Administrators

FROM: J. W. Luna, Commissioner

SUBJECT: Implementation of Linton v. Commissioner

On April 22, 1990, the U.S. District Court for the Middle District of Tennessee ruled that Tennessee's practice of permitting nursing homes to certify less than all available beds was in violation of federal law and regulations. On June 4, 1990, the Court accepted the Department's plan, a copy of which is included as Attachment 1. Most of the aspects of the plan must be implemented immediately. The following are the most significant aspects of the plan with which nursing homes participating in Medicaid must comply:

1. All licensed beds in a Medicaid participating facility must be certified for Medicaid. The State will submit the appropriate information to the Bureau of Medicaid to certify all beds. No specific request by the facility will be necessary.

   a. Facilities which offer nursing home services only at the skilled level of care (SNF) will have all licensed beds

certified for Medicaid participation at the SNF level.

b. Facilities which offer nursing home services only at the intermediate level of care (ICF) will have all licensed beds certified for Medicaid participation at the ICF level.

c. Facilities which offer nursing home services at both the SNF and ICF levels of care will have all SNF beds dually certified, that is, certified for both SNF and ICF participation. All other licensed nursing home beds will be certified as ICF only.

2. Each facility must maintain a single waiting list of applicants and admit residents on a first come first served basis with no private pay preference. The State will permit skipping applicants on the waiting list only for the reasons specified in the rules. The applicant must be given written confirmation that they are on the waiting list and the date and time of entry.

3. No facility will be permitted to transfer or discharge a resident because the resident's source of payment is Medicaid.

4. Residents who are currently paying for nursing home care with non-Medicaid funds and who exhaust those resources shall be encouraged to and entitled to apply for Medicaid. No resident may be transferred or discharged involuntarily because their source of payment has changed to Medicaid.

5. Effective upon judicial approval of this plan, residents who are Medicaid eligible as of June 1, 1990, but who are in facilities that have not sought Medicaid reimbursement for that resident because a Medicaid certified bed had not been available will not be required to pay any more than the resident's liability as determined by the Department of Human Services (e.g., social security, VA, Champus benefits, etc.). The facility will be required to make residents aware that it cannot transfer the residents because their source of payment

has changed to Medicaid and will be required to encourage and assist all residents to apply for Medicaid. A Medicaid eligible resident is one who has an approved Pre-Admission Evaluation and has been determined to be financially eligible by the Department of Human Services. A resident whose PAE has been denied shall be considered Medicaid eligible until the exhaustion of their Medicaid appeals consistent with Doe v. Word, No. 3-84-1260 (M.D. Tenn.).

6. All residents who are determined to be financially eligible for Medicaid participation by the Department of Human Services as of June 1, 1990, but who have not submitted a PAE, or who have applied and not been finally denied, will also pay no more than the resident's liability as determined by DHS, until a PAE is denied and their appeals have been exhausted under Doe v. Word, Id.

7. The facility will also be required to place the attached poster notice at the facility prepared by the Department which provides notification concerning applicant's and resident's rights under the plan. You must provide on the notice, the address and telephone number for the regional Ombudsman, Legal Services Office, and Department of Health and Environment.

8. All participating facilities must also comply with the Title VI requirements as described in the plan. This requirement applies to all Medicaid participating facilities and all licensed only facilities which are owned by an entity or organization which participates in Medicaid. All nursing homes whose reported census of black residents is 10 percentage points (10%) or more below the percentage of black citizens age 65 or older in the county or service area in which the facility is located, will be presumed to be out of compliance with the plan. Such findings will trigger an evaluation of the facility and it will be required to plan affirmative action steps to improve access of racial minorities to the facility's services.

9. A facility which decides to voluntarily withdraw from Medicaid participation will not be permitted to reenroll in the program for a period of two years after the provider agreement is terminated. If the facility is involuntarily terminated from Medicaid, the facility cannot reenroll in the program for a period of at least five (5) years after the provider agreement is terminated.

10. Facilities that wish to voluntarily withdraw from Medicaid participation will not be permitted to involuntarily transfer or discharge current residents except as provided in the plan. As long as such current residents remain in the facility, the facility must comply with all Medicaid requirements.

To assist you in understanding the requirements the Court has ordered, I am enclosing a copy of the relevant portions of the State's plan, Medicaid rules for implementation, and Commissioner's rules for civil rights enforcement, and required notices. The items listed above are highlighted for your information; however, you should read and be familiar with this plan and all rules and regulations.

Please direct all questions or inquiries concerning implementation of the Linton plan to Leslie A. Brown, Director of Health Care Facilities, 283 Plus Park Boulevard, Nashville, Tennessee 37247, (615) 367-6303.

STATE OF TENNESSEE
DEPARTMENT OF HEALTH AND ENVIRONMENT
CORDELL HULL BUILDING
NASHVILLE, TENNESSEE 37219-5402

NED McWHERTER
GOVERNOR

J. W. LUNA
COMMISSIONER

May 31, 1990

Mr. Thomas T. Williams
Regional Director, HHS
101 Marietta Tower
Atlanta, Georgia 30323

Dear Mr. Williams:

On April 23, 1990, the United States District Court, Middle District, Tennessee, issued a memorandum decision in the case of Linton v. Commissioner, M.D. Tenn. No. 3-87-0941. See Attachment 1. The Court, in effect, ruled that Tennessee's practice of allowing Medicaid participating facilities to certify less than all beds for Medicaid violated federal law, created a disparate impact on minorities and violated numerous federal regulations. At page 22 and 25 of the Memorandum, the Court ordered the State to develop a plan to redress the disparate impact on minorities in consultation with HCFA.

The parties to the lawsuit have agreed that the attached plan adequately complies with federal requirements and the Court's Order. See Attachment 2.

This plan is submitted to you for your information and advice. If you believe the plan does not adequately address Medicaid and Title VI requirements, we would appreciate your prompt reply.

If you have questions, please let us know.

Sincerely,

/ S /

J.W. Luna
Commissioner

/ S /

Gordon Bonnyman
Attorney for the Plaintiff

IMPORTANT NOTICE OF YOUR RIGHTS

This nursing home gets Medicaid funds. No person can be kept from making application or being admitted to this nursing home on a first-come, first-served basis because their source of payment is Medicaid.

If you apply for admission to this nursing home, your name is put on a wait list. You can see the wait list and copy it if you choose. You can also call us and we will tell you by phone where you stand on the wait list.

If you are eligible for Medicaid, this nursing home must seek Medicaid payment for your care. We cannot transfer or discharge you if your source of payment changes to Medicaid.
It is unlawful for this nursing home to charge you private pay rates after you have applied for Medicaid, and while Medicaid is deciding whether it will pay for your care. If Medicaid turns you down, you do not have to pay if you appeal, unless you lose your appeal. If you apply for Medicaid and are finally turned down, you may have to pay the nursing home for the care you have received.

You do not have to sell you [*sic*] home, if you own one, in order to get Medicaid. The nursing home cannot ask you to sell you [*sic*] home or to pay private rates for a certain amount of time before you apply for Medicaid. The nursing home must help you in applying for Medicaid if you need help.

This nursing home shall not deny admission to any person on the basis of race, color, national origin or handicapping condition, or method of payment.

If you have questions about your rights or need assistance, free services are available from:

Your Local Long Term Care Ombudsman:
Name: _____
Address: _____
Phone: _____

Your Local Legal Services program:
Name: _____
Address: _____
Phone: _____

Nearest Office of the Dept. of Health & Environment
Name: _____
Address: _____
Phone: _____

DATE:

TO: Medicaid Eligible Residents

FROM: Administrator

RE: Voluntary Termination as a Medicaid Provider

Effective _____, this facility has elected to withdraw from the Medicaid program as a payment source for your nursing home care. Since you have been a resident here prior to our termination decision, you will be allowed to remain here as long as you wish and Medicaid will continue to pay.

If you choose to transfer to another nursing facility, we will give you all the information that you will need to make the right choice as well as help you make the transfer in a safe and orderly manner. We want you to feel comfortable about your move and will not force you to move until you are ready to do so. Because we have requested to withdraw from the Medicaid program, the Department of Health and Environment will monitor your transfer and continued stay in our facility.

If you have questions or need assistance regarding your rights as a nursing home resident, you may contact the Ombudsman, Legal Service, or the Tennessee Department of Health and Environment. Their addresses and phone numbers are listed on the back of this page. Their services are free.

60 a

DATE:

TO: Residents Who Are Not Now Covered by Medicaid

FROM: Administrator

RE: Voluntary Termination as a Medicaid Provider

Effective _____, this facility has elected to withdraw from the Medicaid program as a payment source for nursing home care. Should your present payment source end you will be able to apply for and convert to Medicaid to pay for your care up to June 30, 1991. After June 30, 1991, Medicaid will not longer pay for your care.

If you choose to remain in this nursing home, it will still have a license, and will have to comply with state laws and rules. However, there are additional rights and protections for all residents of nursing homes that get Medicaid funds. After this nursing home withdraws from the Medicaid program those additional rights and protections will no longer apply to residents who remain here.

If you choose to transfer, we will provide you with a list of nursing facilities who do participate in the Medicaid program and help you make the best choice to suit your care needs. Our staff will be available to answer questions and prepare you for a transfer once you are ready to do so.

If you choose to stay with us until the June 30, 1991 date, we will place your name on the waiting lists of all nursing facilities that you choose. At the time you are ready to transfer, we will be available to assist you with the entire process and make this as easy a change as possible.

Since we have chosen to withdraw from the Medicaid program, the Department of Health and Environment will be supervising and monitoring all transfers and continued stays until transferred.

If you have questions or need assistance regarding your rights as a nursing home resident, you may contact the Ombudsman, Legal Services, or the Tennessee Department of Health and Environment. Their addresses and phone numbers are listed on the back of this page. Their services are free.

DATE:

TO: Current Applicants on Wait List

FROM: Administrator

RE: Voluntary Termination as a Medicaid Provider

Effective _____, this facility has elected to withdraw from the Medicaid program as a payment source for nursing home care. Current legal rights and protections that apply to all residents will no longer be in effect once the Medicaid program is terminated.

Since you have placed your name on our list prior to this decision, we will assist you, under the supervision of the Department of Health and Environment, in seeking placement in another nursing facility.

Someone from our staff will be contacting you in the near future to assist with this process.

If you have questions or need assistance regarding your rights as a nursing home resident, you may contact the Ombudsman, Legal Services, or the Tennessee Department of Health and Environment. Their addresses and phone numbers are listed on the back of this page. Their services are free.

IMPORTANT NOTICE OF YOUR RIGHTS

This nursing home gets Medicaid funds. No person can be kept from making application or being admitted to this nursing home on a first-come, first-served basis because their source of payment is Medicaid.

If you apply for admission to this nursing home, your name is put on a wait list. You can see the wait list and copy it if you choose. You can also call us and we will tell you by phone where you stand on the wait list.

If you are eligible for Medicaid, this nursing home must seek Medicaid payment for your care. We cannot transfer or discharge you if your source of payment changes to Medicaid.
It is unlawful for this nursing home to charge you private pay rates after you have applied for Medicaid, and while Medicaid is deciding whether it will pay for your care. If Medicaid turns you down, you do not have to pay if you appeal, unless you lose your appeal. If you apply for Medicaid and are finally turned down, you may have to pay the nursing home for the care you have received.

You do not have to sell your home, if you own one, in order to get Medicaid. The nursing home cannot ask you to sell you [*sic*] home or to pay private rates for a certain amount of time before you apply for Medicaid. The nursing home must help you in applying for Medicaid if you need help.

This nursing home shall not deny admission to any person on the basis of race, color, national origin or handicapping condition, or method of payment.

If you feel your admission or continued stay rights as a Medicaid recipient have been violated, you are urged to contact your local Long-Term Care Ombudsman, Legal Services, or the department of Health and Environment. Their addresses and phone numbers are on the back of this page. Their services are free.

Date

Dear _____:

This letter will serve as notice to you that we no longer have the policy to transfer a Medicaid recipient because a Medicaid certified bed was not available. We now have all of our beds certified to accept Medicaid as a source of payment and will accept any person that applies on a first come first serve basis regardless of the payment source.

We apologize for any inconvenience this may have caused you.

Sincerely,

_____

cc: Patient Care Advocate
Department of Health & Environment

PUBLIC NECESSITY RULES
OF THE TENNESSEE DEPARTMENT
OF HEALTH AND ENVIRONMENT

DIVISION OF MEDICAID

CHAPTER 1200-13-1
GENERAL RULES

AMENDMENTS

Rule 1200-13-1-.01 DEFINITIONS is amended by addition of new paragraphs (15) through (18) which shall read as follows:

(15) Applicant shall mean any person who seeks admission to nursing home care and is not limited to those persons who have completed an official application or have complied with the nursing home's preadmission requirements. The term shall include all persons who have affirmatively expressed an intent to be considered for current or future admission to the nursing home or requested that their name be entered on any "wait list". Persons who only make casual inquiry concerning the nursing home or its admission practices, who request information on these subjects, or who do not express any intention that they wish to be actively considered for admission shall not be considered applicants. All persons, whether applicants or non-applicants, who contact a nursing facility to casually inquire about the facility's services or admissions policies shall be informed by the facility of that person's right to apply for admission and be considered for admission on a non-discriminatory basis and in conformance with Rule 1200-13-1-.08 and Tennessee Code Annotated 68-11-910(b).

(16) Medicaid-eligible resident shall mean any person who has been determined financially eligible for medical assistance by the Tennessee Department of Human Services and who has an approved PAE.

(17) Involuntary transfer or discharge shall mean any transfer or discharge that is opposed by the resident or a representative of the resident. For purposes of compliance with the requirements of Rule 1200-13-1-.05(18), a discharge or transfer is involuntary when the nursing home initiates the action to transfer or discharge.

(18) Notice, when used in regulations pertaining to nursing facilities, shall mean notification that must be provided by the nursing facility to "residents" or "applicants", and shall also include notification to the person identified in a PAE application as the resident's or applicant's designated representative and any other individual who is authorized by law to act on the resident's or applicant's behalf or who is in fact acting on the resident's or applicant's behalf in dealing with the nursing facility.

Rule 1200-13-1-.08 ADMISSIONS TO INTERMEDIATE CARE FACILITIES AND SKILLED NURSING FACILITIES is amended by deleting paragraphs (1) through (4) in their entirety, replacing them with new paragraphs (1) through (8) and renumbering existing paragraph (5) as paragraph (9). New paragraphs (1) through (8) shall read as follows:

(1) Each nursing facility participating in the medical assistance program must develop and consistently implement policies and procedures regarding its admissions, including the development and maintenance of a single wait list of persons requesting admission to those facilities. This list must at a minimum contain the following information pertaining to each request for admission:

(a) The name of the applicant.

(b) The name of the contact person or designated representative other than the applicant (if any).
(c) The address of the applicant and the contact person or designated representative (if any).
(d) The telephone number of the applicant and the contact person or designated representative (if any).
(e) The name of the person or agency referring the applicant to the nursing facility.
(f) The sex and race of the applicant.
(g) The date and time of the request for admission.
(h) Reason(s) for refusal/non-acceptance/other-action-taken pertaining to the request for admission.
(i) The name and title of the nursing facility staff person taking the application for admission..
(j) A notation stating whether the applicant is anticipated to be Medicaid eligible at time of admission or within one year of admission.

(2) The wait list should be updated and revised at least once each quarter to remove the names of previous applicants who are no longer interested in admission to the nursing home. Following three (3) contacts each separated by a period of at least ten (10) days, the nursing home shall, consistent with the written notice required in this section move an applicant to the end of the single admission list whenever an available bed is not accepted at the time of the vacancy, but the applicant wishes to remain on the admissions list. Applicants shall be advised of these policies at the time of their inquiry, and must be notified in writing, in a format approved by the Department, when their name is removed from the list or moved to the end of the list. Such contacts shall be documented in the facility log containing the wait list. The date, time and method of each contact shall be recorded along with the name of the facility staff person making the contact, and the identity of the applicant or contact person contacted. The log of such contacts shall also summarize the communication between the facility staff person and the applicant or contact person.

(3) Each facility shall send written confirmation that an applicant's name has been entered on the wait list, their position on the wait list, and a notification of their right of access to the wait list is provided in paragraph (8) of these rules. This confirmation shall include at a minimum the date and time of entry on the wait list and shall be mailed by first class postage to the applicant and their designated representative (if any) identified pursuant to the requirements in paragraph (1) above.

(4) Each nursing facility participating in the medical assistance program shall admit applicants in the chronological order in which the referral or request for admission was received by the facility, except as permitted in paragraph (5) of this rule.

(5) Documentation justifying deviation from the order of the wait list must be maintained for inspection by the Department. Inspection shall include the right to review and/or make copies of these records. Deviation may be based upon:

(a) Medical need, including, but not necessarily limited to, the expedited admission of patients being discharged from hospitals and patients who previously resided in a nursing home at a different level of care, but who, in both cases, continue to require institutional medical services;

(b) The applicant's sex, if the available bed is in a room or a part of the nursing home that exclusively serves residents of the opposite sex;

(c) Necessity to implement the provisions of a plan of affirmative action to admit racial minorities, if the plan has previously been approved by the Department;

(d) Emergency placements requested by the Department when evacuating another health care facility or by the

Adult Protective Service of the Tennessee Department of Human Services;

(e) Other reasons or policies, e.g., previous participation in a community based waiver or other alternative care program, when approved by the Medical Director of the Department's Bureau of Manpower and Facilities; provided, however, that no such approval shall be granted if to do so would in any way impair the Department's or the facility's ability to comply with its obligations under federal and state civil rights laws, regulations or conditions of licensure or participation.

(f) If a Medicaid-eligible recipient's hospitalization or therapeutic leave exceeds the period paid for under The Tennessee Medicaid program for the holding of a bed in the facility for the resident and if the resident continues to require the services provided by the nursing home, then the resident must be readmitted to the facility immediately upon the first availability of a bed in the facility, consistent with paragraph (5)(b);

(g) Where, with the participation and approval of the Department, expedited admission is approved for residents who are being displaced from another facility or its waiting list as a result of that facility's withdrawal from the Medicaid program.

(6) Telephone requests to be placed on the wait list shall be accepted. The information required in paragraph (1) shall be documented.

(7) If an applicant, whether on his or her own behalf or acting through another, requests admission or to be placed on a list of applicants awaiting admission, the information on the waiting list must be recorded and preserved.

(8) Applicants (or their representative), Ombudsmen and

appropriate State and Federal Personnel shall have access to the wait list when requested. Such access shall include the right to review an/or copy the wait list, and to be informed by telephone of their position on the wait list.

Rule 1200-13-1-.05 PROVIDERS is amended by addition of new paragraphs (15) through (18) which shall read as follows:

(15) Nursing facilities who choose to voluntarily terminate their provider agreement may do so by notifying the Department in writing of such intent.

(a) The effective date of the termination will be determined by the Department. The notification must provide the following information:

1. The reason(s) for voluntary termination;

2. The names and Medicaid identification number of all Medicaid-eligible residents;

3. The name of the resident and name of the contact person for the resident (if any) for residents with an application for Medicaid eligibility pending;

4. A copy of the letter the facility will send to each resident informing them of the voluntary termination, and a copy of the letter to be sent to all Medicaid-eligible residents regarding this action;

5. A copy of the letter sent to all applicants on the wait list informing them of the facilities voluntary termination; and

6. Other information determined by the Department as necessary to process the request for termination.

(b) The termination of the provider's involvement in

Medicaid must be done in such a manner as to minimize the harm to current residents.

1. Residents who are currently Medicaid-eligible shall be informed, in a notice to be provided by the facility and approved by the Department, that the facility has elected to withdraw from the Medicaid program. The notice shall inform the resident of the right to remain in the facility as a Medicaid patient as long as they wish to do so and remains otherwise eligible under the rules of the Medicaid Program. The notice shall also inform the resident that, if they wish to transfer to another facility, under the supervision of the Department, the nursing home where they now reside will assist in locating a new placement and providing orientation and preparation for the transfer, in accordance with 42 U.S.C. S [*sic*] 1396r(c)(2)(C) and implementing regulations and guidelines, if any.

2. All other residents of the facility shall receive a separate notice informing them of the facility's intention to withdraw from the Medicaid program. The notice will be provided by the facility after having been first reviewed and approved by the Department. The notice shall inform such residents that, should they become eligible for Medicaid coverage, they will be able to convert to Medicaid from their current source of payment and remain in the facility thereafter. Transfer of these residents shall be considered an involuntary transfer and shall comply with Department regulations governing involuntary transfer or discharges.

   The same notice will caution these residents that, if they require care as Medicaid patients beyond June 30, 1991, they will have to transfer to another facility. The notice will also inform the residents

that, when their present facility is no longer participating in the Medicaid program, certain legal rights and protections that apply to all residents (regardless of source of payment) in Medicaid facilities will no longer be available to those who remain in the nursing home. Readers of the notice will be informed that, if they wish to transfer, or to have their names placed on wait lists at other facilities, the nursing home that is withdrawing from the program will assist them by providing preparation and orientation, under the supervision of the Department, as required by 42 U.S.C. S [*sic*] 1396r(c)(2)(C) and implementing regulations and guidelines, if any.

3. Applicants whose names are on the facility's wait list will be notified by the facility, on a form that has been reviewed and approved by the Department, that the facility intends to withdraw from the Medicaid program. They will be cautioned that they will not be able to obtain Medicaid coverage for any care that they receive in the facility. The notice shall also inform them that certain legal rights and protections that apply to all residents (regardless of source of payment) in Medicaid-participating facilities will not be available in the nursing home to which they have applied, once that facility has withdraw from the Medicaid program.

   Applicants will be informed in the notice that, if they wish to make application at other facilities, the withdrawing facility, under the supervision of the Department, shall assist them in seeking placement elsewhere.

4. After June 30, 1991, or the date on which the last Medicaid-eligible resident is lawfully and

appropriately transferred or discharged, whichever event occurs later, the nursing facility will be decertified and its Medicaid provider agreement terminated.

(c) Facilities who notify the Department of their intent to voluntarily terminate Medicaid participation may rescind such notification within fifteen (15) days of receipt of the notification by the Department. Notices of voluntary termination shall automatically become irrevocable after fifteen (15) days unless Department approval is obtained to waive this provision. Facilities which voluntary terminate their provider participation agreements shall not be permitted to participate in the Medicaid program for a minimum of two (2) years from the date of the termination.

(16) Nursing facilities may be involuntarily decertified by the Department because of their failure to comply with the provisions of Medicaid General Rule, Chapter 1200-13-1. Facilities that are involuntarily decertified shall not be permitted to participate in the Medicaid program for a minimum of five (5) years from the date of decertification.

(17) Nursing facilities participating in the Medicaid Program shall not:

(a) Involuntarily transfer or discharge a Medicaid-eligible resident because Medicaid has been or becomes the resident's source of payment for nursing home care.

(b) Seek payment of an amount from a Medicaid-eligible resident in excess of the amount of patient liability determined by the Tennessee Department of Human Services.

(c) Seek payment in excess of the amount of patient liability determined by the Tennessee Department of

Human Services from any resident who is financially eligible for medical assistance but who has not submitted a PAE for consideration or whose appeal rights for a denied PAE have not been exhausted.

(18) Nursing facilities participating in the Medicaid Program must comply with the following guidelines regarding transfers, discharges and/or readmissions.

(a) Transfer and Discharge Rights - A nursing facility must permit each resident to remain in the facility and must not transfer or discharge the resident from the facility unless:

1. The transfer or discharge is necessary to meet the resident's welfare which cannot be met in the facility;

2. The transfer or discharge is appropriate because the resident's health has improved sufficiently so the resident no longer needs the services provided by the facility;

3. The safety of individuals in the facility is endangered;

4. The health of individuals in the facility would otherwise be endangered;

5. The resident has failed, after reasonable and appropriate notice, to pay (or to have paid under Title XIX or Title XVIII on the resident's behalf) for a stay at the facility; or

6. The facility ceases to operate.

In each of the cases described above, no patient shall be discharged or transferred without a written order

from the attending physician or through other legal processes and timely notification of next of kin and/or sponsor or authorized representative, if any. Each nursing home shall establish a policy for handling patients who wish to leave the home against medical advice. The basis for the transfer or discharge must be documented in the resident's clinical record. In the cases described in the clauses (a)1. and (a)2., the documentation must be made by the resident's physician, and in the case described in clause (a)4. the documentation must be made by a physician. For purposes of clause (a)5., in the case of a resident who becomes eligible for assistance under Title XIX after admission to the facility, only charges which may be imposed under Title XIX shall be considered to be allowable.

When a patient is transferred, a summary of treatment given at the nursing home, condition of patient at time of transfer and date and place to which transferred shall be entered in the record. If transfer is due to an emergency, this information will be recorded within forty-eight (48) hours; otherwise, it will precede the transfer of the patient.

When a patient is transferred, a copy of the clinical summary should, with consent of the patient, be sent to the nursing home that will continue the care of the patient.

Where an involuntary transfer is proposed, in addition to any other relevant factors, the following factors shall be taken into account:

1. The traumatic effect on the patient.

2. The proximity of the proposed nursing home to the present nursing home and to the family and friends

of the patient.

3. The availability of necessary medical and social services at the proposed nursing home.

4. Compliance by the proposed nursing home with all applicable Federal and State regulations.

(b) Pre-Transfer and Pre-Discharge Notice - Before effecting a transfer or discharge of a resident, a nursing facility must:

1. Notify the resident (and, if known, a family member of the resident or legal representative) of the transfer or discharge and the reasons therefore.

2. Record the reasons in the resident's clinical record (including any documentation required pursuant to (a) above and include in the notice the items described in (d) below.

3. Notify the Department and the long-term care Ombudsman.

4. Not transfer or discharge a resident until the above agencies have designated their intention to intervene and until any appeal process is complete, should the resident request a fair hearing.

(c) Timing of Notice - The notice under (b) must be made at least 30 days in advance of the resident's transfer or discharge except:

1. In a case described in (a)3. or (a)4. above.

2. In a case described in (a)2. where the resident's health improves sufficiently to allow a more immediate transfer or discharge.

3. In a case described in (a)1. where a more immediate transfer or discharge is necessitated by the resident's urgent medical needs.

4. In a case where a resident has not resided in the facility for 30 days.

In the case of such exceptions, notice must be given as many days before the date of the transfer or discharge as is practicable.

(d) Items included in notice - Each pre-transfer and pre-discharge notice under (b) must include:

1. For transfers or discharges effected on or after October 1, 1989, notice of the resident's right to appeal the transfer or discharge.

2. The name, mailing address, and telephone number of the State long-term care ombudsman.

3. In the case of residents with developmental disabilities, the mailing address and telephone number of the agency responsible for the protection and advocacy system for developmentally disabled individuals.

4. In the case of mentally ill residents, the mailing address and telephone number of the agency responsible for the protection and advocacy system for mentally ill individuals established under the Protection and Advocacy for Mentally Ill Individuals Act.

(e) Orientation - A nursing facility must provide sufficient preparation and orientation to residents to ensure safe and orderly transfer or discharge from the facility.

(f) Notice of Bed-Hold Policy and Readmission - Before a resident of a nursing facility is transferred for hospitalization or therapeutic leave, a nursing facility must provide written information to the resident and a family member or legal representative concerning:

1. The provisions of the State plan under this Title XIX regarding the period (if any) during which the resident will be permitted under the State plan to return and resume residence in the facility, and

2. The policies of the facility consistent with (g) below, regarding such a period.

(g) Notice Upon Transfer - At the time of transfer of a resident to a hospital or for therapeutic leave, a nursing facility must provide written notice to the resident and a family member or legal representative of the duration of any period under the State plan allowed for the resumption of residence in the facility.

Paragraph (9) of Rule 1200-13-1-.05 PROVIDERS is amended by addition of a new subparagraph (g) which shall read as follows:

(g) All nursing facilities shall establish written policies and procedures addressing admission, transfer and discharge, consistent with Medicaid General Rule, Chapter 1200-13-1. These policies and procedures shall be available for inspection by the Department.

Signature of the agency officer or officers directly responsible for proposing and/or drafting these rules:

Manuel Martins
Assistant Commissioner
for Medicaid Administration
Tennessee department of Health
and Environment

I certify that this is an accurate complete representation of the intent and scope of rulemaking proposed by the Tennessee Department of Health and Environment.

J. W. Luna
Commissioner

Subscribed and sworn to before me this the _____ day of _____ 19 _____.

Notary Public

My commission expires on the ___ day of _____, 19___.

All Public Necessity Rules provided for herein have been examined by the Attorney General and Reporter of the State of Tennessee and are approved as to legality pursuant to the provisions of the Administrative Procedures Act, Tennessee Code Annotated, Title 4, Chapter 5.

Charles W. Burson
Attorney General and Reporter

The Public Necessity Rules set out herein were properly filed in the Department of State on the _____ day of _____, 19 ____ and will be effective from the date of filing for a period of _____ days. The Public Necessity Rules will remain in effect through the _____ day of _____, 19 ____.

_____

Bryant Millsaps
Secretary of State

By:_____

PUBLIC NECESSITY RULES OF TENNESSEE DEPARTMENT OF HEALTH AND ENVIRONMENT OFFICE ON CIVIL RIGHTS COMPLIANCE

CHAPTER 1200-24-3
CIVIL RIGHTS COMPLIANCE PENALTY PROGRAM RULES AND REGULATIONS

NEW RULES
TABLE OF CONTENTS

1200-24-3-.01 PURPOSE
1200-24-3-.02 DEFINITIONS
1200-24-3-.03 SANCTIONS
1200-24-3-.04 TYPES OF CIVIL PENALTIES
1200-24-3-.05 REPEATED AND MAXIMUM PENALTIES

1200-24-3-.01 PURPOSE

The purpose of these rules is to provide regulatory guidance for assessing civil penalties pursuant to T.C.A. § 68-1-113. The rules apply only to nursing homes as defined at T.C.A. § 68-11-201 and licensed by the department for the purpose of assisting in enforcing compliance with Title VI of the Civil Rights Act of 1964, as amended and requirements of Linton v. Commissioner, M.D. Tenn, No. 3-87-0941.

1200-24-3-.02 DEFINITIONS

(1) "HEALTH CARE FACILITY": Any facility licensed under the authority of the Board for Licensing Health Care Facilities as defined in T.C.A. § 68-11-201.

(2) "CIVIL RIGHTS": Personal and individual rights guaranteed by the federal or state constitution and/or any federal or state statute.

(3) "COMMISSIONER": The Commissioner of the Tennessee Department of Health and Environment or his designated representative.

(4) "DEPARTMENT": Tennessee Department of Health and Environment

(5) "TITLE VI": Title VI of the Civil Rights Act of 1964, as amended (42 USC § 2000d)

(6) "MINORITY": Persons who fall within the following categories: Black, not of Hispanic origin; Hispanic; American Indian; Alaskan Native; Asian or Pacific Islander.

(7) "DISCRIMINATION": Any act, policy, practice, or procedure which results in different treatment based on race, color, national origin or method of payment that impacts adversely upon minorities and others protected under Title VI of the Civil Rights Act of 1964.

(8) "OFFICE ON CIVIL RIGHTS COMPLIANCE (OCRC)": The administrative, regulatory and enforcement unit established within the Department of Health and Environment charged with responsibility of monitoring and investigating complaints related to civil rights compliance of facilities regulated by the Board.

Statutory Authority: T.C.A. §§ 4-3-1803(1), 68-1-103(b), and 68-1-113, 4-5-209.

1200-24-3-.03 SANCTIONS

Pursuant to T.C.A. § 68-1-113, the Commissioner of the Department of Health and Environment shall have the authority to impose civil penalties upon deficient health care facilities licensed as nursing homes. Based upon the investigation of the Office on Civil Rights Compliance and the severity of the discriminatory practice, the Commissioner may impose civil penalties as provided

in this section. Civil penalties may be assessed in minimum and maximum amounts as follows:

(a) Type I civil penalties may be assessed in the amount of not less than three thousand five hundred dollars ($3,500) and not more than five thousand dollars ($5,000);

(b) Type II civil penalties may be assessed in the amount of not less than one thousand five hundred dollars ($1,500) and no more than three thousand five hundred dollars ($3,500);

(c) Type III civil penalties may be assessed in the amount of not less than five hundred dollars ($500) and no more than one thousand five hundred dollars ($1,500).

Statutory Authority: T.C.A. §§ 4-3-1803(1), 68-1-103(b), 68-1-113, and 4-5-209.

1200-24-3-.04 TYPES OF CIVIL PENALTIES

(1) A Type I civil penalty may be assessed if the health care facility engages in discrimination which impacts negatively on the health, safety and welfare of multiple minority patients. Examples of practices which may lead to the imposition of a Type I civil penalty are:

(a) Denying persons admission to the facility on the basis of race, color, creed and national origin, or method of payment as provided by state or federal law, rules or regulations.

(b) Transferring multiple patients from one room to another on the basis of racial or source of payment considerations (except for affirmative action remedies which pose no risk to patients).

(c) Clustering patients on the basis of race, color, creed or national origin or source of payment on specific floors, sections, or wings of the facility.

(d) Not admitting applicants to a facility on a first come first serve basis as required by State or federal laws rules or regulations.

(e) Retaliating against residents or staff because of complaints made to the Department.

(2) A Type II Civil penalty may be assessed if the Health Care Facility utilizes a policy or procedure that is likely to be detrimental to a patient and the facility refuses to correct the violation. Examples of practices which may lead to the imposition of a Type II Civil Penalty are:

(a) Denial of admission of a single individual on the basis of race, creed, color or national origin or method of payment as provided by state or federal law or rules or regulations;

(b) Assigning a room or transferring a single individual on the basis of race, creed, color or national origin or method of payment contrary to state or federal law, rules or regulations.

(c) Providing segregated services, e.g., beauty and barber shops, dining rooms, lounges.

(d) Denial of an individual the opportunity to participate on a planning or advisory board on the basis of race, color, national origin, or method of payment as required by state or federal law, rules or regulations.

(e) Retaliating against an individual resident or staff member because of complaints made in good faith to the Department.

(3) A Type III civil penalty may be assessed for deficiencies that do not directly involve a specific individual but violate state and federal law, rules or regulations. Examples which may lead to a Type III civil penalty may include:

(a) Failure to develop an acceptable plan of correction within the time required.

(b) Failure to make available all data and pertinent information requested by OCRC.

(c) Failure to notify referral sources and the minority community that services are provided in a non-discriminatory manner as required by state or federal law, rules or regulations.

(d) Failure to display in prominent places the required compliance statements as required by state or federal law, rules or regulations.

(e) Failure to make adequate or appropriate notification of the facility's commitment to providing services in a non-discriminatory manner as required by state or federal law, rules or regulations.

(f) Failure to include a non-discriminatory statement in all vendor contracts and brochures and other information distributed to the public as required by state or federal law, rules or regulations.

Statutory Authority: T.C.A. §§ 4-3-1803(1), 68-1-103(b), and 68-1-113, 4-5-209

1200-24-3-.05 REPEATED AND MAXIMUM PENALTIES

(1) Penalties may be imposed simultaneously for multiple and distinct civil rights violations.

(2) If corrective action is not accomplished within a time period approved by OCRC a civil penalty with the initial amount may be imposed.

Statutory Authority: T.C.A. §§ 4-3-1803(1), 68-1-103(b), and 68-1-113, 4-5-209.

Signature of the agency or officers directly responsible for proposing and/or drafting these rules:

_____
Beverly Bass, Director
Office on Civil Rights Compliance

I certify that this is an accurate and complete copy of Public Necessity Rules lawfully promulgated and adopted by the Department of Health and Environment on _____, 1990.

_____
J. W. Luna
Commissioner

Subscribed and sworn to before me this the _____ day of _____, 1990.

_____
Notary Public

My commission expires on the _____ day of _____, 1990.

All Public Necessity Rules provided for herein have been examined by the Attorney General and Reporter of the State of Tennessee and are approved as to legality pursuant to the provisions of the Administrative Procedures Act, Tennessee Code Annotated, Title 4, Chapter 5.

_____

Charles W. Burson
Attorney General and Reporter

The Public Necessity Rules set out herein were properly filed in the Department of State on the _____ day of _____, 1990, and will be effective from the date of filing for a period of _____ days. The Public Necessity Rules will remain in effect through the _____ day of _____, 1990.

_____

Bryant Millsaps
Secretary of State

RULES OF TENNESSEE DEPARTMENT OF HEALTH AND ENVIRONMENT BOARD FOR LICENSING HEALTH CARE FACILITIES

CHAPTER 1200-8-16
CIVIL RIGHTS COMPLIANCE RULES AND REGULATIONS

NEW RULES

TABLE OF CONTENTS

1200-8-16-.01 Definitions
1200-8-16-.02 Requirements for Civil Rights Compliance
1200-8-16-.03 Monitoring Procedures
1200-8-16-.04 Corrective Action

1200-8-16-.01 DEFINITIONS

(1) "HEALTH CARE FACILITY (FACILITY)": Any facility licensed under the authority of the Board for Licensing Health Care Facilities as defined in T.C.A. 68-11-102.

(2) "CIVIL RIGHTS": Personal and individual rights guaranteed by the federal or state constitution and/or any federal or state statute.

(3) "COMMISSIONER": The Commissioner of the Tennessee Department of Health and Environment or his designated representative.

(4) "DEPARTMENT": Tennessee Department of Health and Environment

(5) "BOARD": Board for Licensing Health Care Facilities

(6) "TITLE VI": Title VI of the Civil Rights Act of 1964, 42

U.S.C. § 2000d.

(7) "SECTION 504": Section 504 of the Rehabilitation Act of 1973, 29 U.S.C. § 794.

(8) "HANDICAPPED PERSON": means any person who (a) has a physical or mental impairment which substantially limits one or more major life activities, (b) has a record of such an impairment, or (c) is regarded as having such an impairment.

(9) "QUALIFIED HANDICAPPED PERSON": (a) With respect to receiving services, means a handicapped person who meets the eligibility requirements for receiving services offered by the facility; (b) With respect to employment, means a handicapped person who, with reasonable accommodations, can perform the essential functions of the job in question without undue hardship to the facility. Reasonable accommodations may include: Making facilities readily accessible to and usable by handicapped persons; providing part-time or modified work schedules; and, providing readers or interpreters. In determining whether an accommodation would result in an undue hardship on the facility, factors to be considered may include: The overall size of the facility with respect to number of employees, number and type of facilities, and size of budget; the type of facility, including the composition and structure of the facility's workforce; and, the nature and cost of the accommodation needed.

(10) "PHYSICAL OR MENTAL IMPAIRMENT": means (a) Any physiological disorder or condition, cosmetic disfigurement, or anatomical loss affecting one or more of the following body systems: neurological; musculoskeletal; special sense organs; respiratory, including speech organs; cardiovascular; reproductive, digestive, genito-urinary; hemic and lymphatic; skin; and endocrine; or (b) any mental or psychological disorder, such as mental retardation, organic

brain syndrome, emotional or mental illness, and specific learning disabilities.

(11) "DISCRIMINATION": Any act, policy, practice, or procedure which result in different treatment based on race, color, national origin or handicapping condition that impacts negatively upon qualified handicapped individuals and others protected under Title VI of the Civil Rights Act of 1964.

(12) "OFFICE ON CIVIL RIGHTS COMPLIANCE (OCRC)": The administrative, unit established within the Tennessee Department of Health and Environment charged with the responsibility of monitoring and investigating complaints related to civil rights compliance of facilities regulated by the Board.

(13) "MINORITY": Persons who fall within the following categories: Black, not of Hispanic origin; Hispanic; American Indian; Asian or Pacific Islander.

Statutory Authority: T.C.A. §§ 68-1-113, 68-11-102, 68-11-203, 4-5-202, U.S.C. 45 Part 80 and U.S.C. 45 Part 84.

1200-8-16-.02 REQUIREMENTS FOR CIVIL RIGHTS COMPLIANCE

The Board for Licensing Health Care Facilities may deny, suspend, or revoke a facility's license, or otherwise discipline the facility, for violations of the following requirements pursuant to T.C.A. 68-11-207 and 68-1-113. Licensed health care facilities must comply with the following:

(1) Shall not directly or through licensing, contractual or other arrangements, utilize criteria or methods of administering services which have the effect of subjecting individuals to discrimination on the basis of race, color, national origin or handicapping condition.

(2) Admission policies and procedures shall include measures to

admit patients/residents to the facility without regard to race, color, national origin or handicapping condition.

(3) Shall include in their operational policies and procedures manuals measures to provide all services in a non-discriminatory manner (i.e. medical, dental, nursing, laboratory, pharmacy, skilled rehabilitative, social, volunteer, dietary and housekeeping).

(4) Physical facilities including lounges, dining facilities, beauty and barber shops shall not be used in a segregated or discriminatory manner.

(5) Shall include in their operational policies and procedures manuals that patients/residents are assigned to rooms, wards, floors, sections, buildings, and other areas without regard to race; color; national origin; or handicapping conditions, unless medically indicated.

(6) Shall include in their operational policies and procedures manuals that all aspects of all their training programs – those operated by the facility, and those operated by other institutions within their facility for which the facility provides clinical training – are conducted without discrimination, on the basis of race, color, national origin or handicapping condition.

(7) Shall use all reasonable efforts to recruit minority and handicapped persons to training programs offered by the facility.

(8) Shall inform all patients/residents, potential patients/residents, and the general public that admissions and services are provided on a non-discriminatory basis. This shall be accomplished by:

(a) If a facility publishes or uses brochures, pamphlets and newsletters which are designed to acquaint potential

patients/residents and members of the general public with the facility's programs and services, a statement of the facility's commitment and compliance to Title VI and Section 504 must be included. All efforts to communicate to the public should convey the message that services are provided in a non-discriminatory manner.

(b) Including a statement of the facility's commitment and compliance to Title VI and Section 504 on all application forms for admission and employment.

(c) Notifying all customary referral sources and the minority community within the service area that the facility's services and benefits are provided in a non-discriminatory manner.

(d) Displaying in prominent places in the facility notices indicating the Title VI and Section 504 compliance and commitment.

(9) Shall be responsible for conveying to all staff their non-discriminatory policy and how to file a complaint under Title VI or Section 504. This shall be accomplished by providing, as part of new employee's orientation and periodic retraining of permanent employees, information regarding the obligation, intent, and meaning of Title VI and Section 504 compliance.

(10) Those facilities with fifteen or more employees shall designate a responsible employee (Section 504 Coordinator) to coordinate its efforts to comply with Section 504 regulations.

(11) Shall establish and adhere to an internal procedure for handling patient/resident and employee grievances. The grievance procedure shall include:

(a) Complainant's right to due process.

(b) Time frames for the review, resolution and/or findings process.

(12) Shall ensure that the opportunity to participate as members of planning, advisory, and policy boards whose membership is opened to the public, is available in a non-discriminatory manner.

(13) Shall develop procedures for monitoring all aspects of its operation to ensure that no policy or practice is, or has the effect of discriminating against applicants, patients/residents, employees or other participants on the basis of race, color, national origin, or handicapping condition. Each facility shall establish a system to review annually all new and existing policies to determine compliance of such policies with Title VI and Section 504.

(14) Shall maintain and make available to the OCRC for the purpose of demonstrating compliance and upon request, all data and information necessary to determine the facility's compliance with Title VI of the Civil Rights Act of 1964 and Section 504 of the Rehabilitation Act of 1973. Such statistical data shall include racial and ethnic data showing the extent to which minority and handicapped individuals participate in the facility's services and programs.

(15) All recruitment and employment practices shall not discriminate on the basis of race, color, national origin, handicapping condition, or have an adverse effect on the provision of services, privileges, or advantages offered to the facility's patients/residents.

(16) Shall include in their operational policies and procedures manuals a procedure for effective communication with handicapped persons and persons with limited English proficiency for the purpose of giving notice concerning benefits, services, waiver of rights, and consent to treatment, including emergency treatment.

(17) Shall provide appropriate auxiliary aids to persons with impaired sensory, manual, or speaking skills, where necessary to afford such persons an equal opportunity to benefit from services provided by the facility. Auxiliary aids may include information in braille, taped material and interpreters.

(18) Shall include an assurance of compliance with Title VI and Section 504 in all contracts with service agencies, health care providers and other health care facilities, e.g. services will be provided in a non-discriminatory manner without regard to race, color, national origin or handicapping condition.

Statutory Authority: T.C.A §§ 68-11-209, 68-11-210, 4-5-202, 45 U.S.C., Part 80 and 45 U.S.C., Part 84.

1200-8-16-.03 MONITORING PROCEDURES

(1) Periodic compliance reviews.

The office on Civil Rights Compliance shall have the authority to periodically review the practices of facilities to determine compliance with these regulations. Whenever a deficiency in compliance is cited by OCRC, a deficiency report shall be submitted to the facility. The facility shall develop and implement an acceptable plan of correction, specifying steps to correct the deficiencies and the time frame in which corrective measures will be taken. An acceptable plan of correction must be returned to OCRC no later than ten (10) days after receipt of the deficiency report, unless an extension is granted by the Director of OCRC or his/her designee. Documentation of already corrected deficiencies may be submitted with the plan of correction. The plan must be approved by the Director of OCRC, or his/her designee.

(2) Non-Compliance Investigations.

The Office on Civil Rights Compliance shall have the

authority to conduct an investigation whenever a compliance review, report, complaint, or any other information indicates a possible failure to comply with State and federal law, and these regulations.

(3) Complaints.

Complaints involving discrimination prohibited by State and federal law may be filed with the Office on Civil Rights Compliance by the complainant or his or her representative. The identity of complainants shall be kept confidential to the extent the law permits.

(4) Intimidatory or Retaliatory Acts Prohibited.

No health care facility shall retaliate against or, in any manner, discriminate against any person because of a complaint made in good faith and without malice to the Board or the Department, or other agency having jurisdiction in the matter. A health care facility shall neither retaliate, nor discriminate against the complainant because of information provided to these authorities.

Statutory Authority: T.C.A. §§ 68-11-209, 4-5-202, 45 U.S.C., Part 80, and 45 U.S.C., Part 84.

1200-8-16-.04 CORRECTIVE ACTION

If the facility has discriminated, or policies and procedures have resulted in discrimination against persons on the ground of race, color, national origin or handicapping condition, the facility must take action that will result in correcting the deficiency or the discriminatory act.

Statutory Authority: T.C.A. §§ 68-11-209, 4-5-202, 45 U.S.C., Part 80 and 45 U.S.C., Part 84.

Appendix C

STATE OF TENNESSEE
DEPARTMENT OF HEALTH AND ENVIRONMENT
CORDELL HULL BUILDING
NASHVILLE, TENNESSEE 37219-5402

NED McWHERTER
GOVERNOR

J. W. LUNA
COMMISSIONER

May 31, 1990

Mr. Thomas T. Williams
Regional Director, HHS
101 Marietta Tower
Atlanta, Georgia 30323

Dear Mr. Williams:

On April 23, 1990, the United States District Court, Middle District, Tennessee, issued a memorandum decision in the case of Linton v. Commissioner, M.D. Tenn. No. 3-87-0941. See Attachment 1. The Court, in effect, ruled that Tennessee's practice of allowing Medicaid participating facilities to certify less than all beds for Medicaid violated federal law, created a disparate impact on minorities and violated numerous federal regulations. At page 22 and 25 of the Memorandum, the Court ordered the State to develop a plan to redress the disparate impact on minorities in consultation with HCFA.

The parties to the lawsuit have agreed that the attached plan adequately complies with federal requirements and the Court's Order. See Attachment 2.

This plan is submitted to you for your information and advice. If you believe the plan does not adequately address Medicaid and Title VI requirements, we would appreciate your prompt reply.

If you have questions, please let us know.

Sincerely,

/ S /

J.W. Luna
Commissioner

/ S /

Gordon Bonnyman
Attorney for the Plaintiff

Appendix D

ENFORCEMENT STRATEGY

The Department will monitor facility compliance with regard to admission practices, during annual surveys as well as for on-site visits and complaint investigations. The monitoring strategy will be based upon each specific situation, but will include as part of the survey, visit or complaint investigation making blind telephone calls to the facility inquiring about admission policies, wait list and Medicaid acceptance. In addition, applicants, residents and/or families or referral sources of applicants or residents may be interviewed. Staff surveyors will inspect and review documentation on admission denials, reasons for by-passing a resident on the wait list, patient transfer, facility census data, operational policies and procedures manuals, and facility advertisements. When the Department finds the facility has violated a requirement of this plan, it will be considered a violation of the facility's policies and procedures. As such a pending Type C penalty notification pursuant to TCA § 68-11-80, will be issued along with a deficiency notice. If a facility is again found out of compliance within a twelve month period a Type C civil monetary penalty of $250 will be issued in accordance with TCA § 68-11-8. Where noncompliance continues or where the noncompliance is pervasive, the Department will consider additional civil monetary penalties, denial, supervision or revocation of the facility's license, involuntary termination from Medicaid; and any other types disciplinary action available to the Commissioner and the Board.

The Department will evaluate as part of its annual facility survey a sample of transfers and discharges to assure that residents have not been transferred in contravention of the plan. In addition the Patient Care Advocacy Program (PCAP) monitors complaints regarding involuntary transfers. Upon determination that a facility transferred or discharged a resident in contravention of this Order, a Type B Civil Monetary Penalty will be issued pursuant to TCA

§ 68-11-80 of up to $1,500. Where the noncompliance continues or where the noncompliance is pervasive, the Department will consider additional civil monetary penalties, denial, suspension, or revocation of the facility's license, involuntary termination from Medicaid, and any other type disciplinary action available to the Commissioner and the Board.

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IN THE UNITED STATES DISTRICT COURT FOR THE MIDDLE DISTRICT OF TENNESSEE, NASHVILLE DIVISION

MILDRED LEA LINTON, by her next friend KATHY ARNOLD, on her own behalf and on behalf of all other persons similarly situated Plaintiff	]	
VS.	]	DOCKET NO. 3-87-0941
BELLE CARNEY, by her next friend MARY KIMBLE, on her own behalf and on behalf of all other persons similarly situated Plaintiff-Intervenor	]	
VS.	]	
COMMISSIONER OF HEALTH AND ENVIRONMENT, STATE OF TENNESSEE	]	

ORDER

In accordance with the contemporaneously entered Memorandum, the Court hereby ORDERS a further hearing in order to determine an appropriate remedy, and further ORDERS the Commission to submit a plan for Court approval that will redress the disparate impact on minority Medicaid patients' access to qualified nursing home care.

Entered this the 20th day of April, 1990.

/ S /
UNITED STATES DISTRICT JUDGE

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IN THE UNITED STATES DISTRICT COURT FOR THE MIDDLE DISTRICT OF TENNESSEE, NASHVILLE DIVISION

MILDRED LEA LINTON, by her next friend KATHY ARNOLD, on her own behalf and on behalf of all other persons similarly situated Plaintiff	]	
VS.	]	DOCKET NO. 3-87-0941
BELLE CARNEY, by her next friend MARY KIMBLE, on her own behalf and on behalf of all other persons similarly situated Plaintiff-Intervenor	]	
VS.	]	
COMMISSIONER OF HEALTH AND ENVIRONMENT, STATE OF TENNESSEE	]	

MEMORANDUM

Plaintiffs are before the Court seeking to enjoin a Tennessee policy through which only a portion of the beds in Medicaid participating nursing homes are certified to be available for Medicaid patients. Plaintiffs allege that this policy artificially limits the accessibility of nursing home care to indigent Medicaid patients and fosters discrimination against indigent patients by nursing homes. Plaintiffs claim that, as a result of the challenged policy, they and other individuals similarly situated face delay or outright denial of needed nursing home care, as well as displacement from current residency in nursing home facilities. Plaintiffs bring this action under 29 U.S.C. § 794, the Rehabilitation Act of 1973; 42 U.S.C. § 1396 (Supp. 1987), et

seq., Title XIX of the Social Security Act, and 42 U.S.C. § 2000d (1982 and Supp. 1987) et seq., Title VI of the Civil Rights Act of 1964, and the Due Process Clause of the Fourteenth Amendment.

Final argument in this action was held on January 27, 1989. The parties subsequently requested an opportunity to settle the due process claim, and that claim is therefore not addressed in this Memorandum. By agreement of the parties, all proof previously submitted to the Magistrate in this case was introduced into evidence, including proof introduced in Jane Doe v. Mid South Nursing Home, Inc., et al, No. 3-87-0760.

The Court, having considered the record in this case, including the pleadings, the stipulations of the parties, the exhibits and the statements of counsel, hereby makes, pursuant to Rule 52 of the Federal Rules of Civil Procedure, the following Findings of Fact and Conclusions of Law as a final adjudication of this matter.

FINDINGS OF FACT

The present case was initiated on December 1, 1987 on behalf of Mildred Lea Linton.[1] Ms. Linton suffers from rheumatoid arthritis and has been a patient for four years at Green Valley Health Care Center in Dickson, Tennessee [hereinafter "Green Valley"]. A Medicaid patient who had been receiving skilled nursing facility (SNF) level care throughout her stay, the plaintiff received notice from State Medicaid officials that she no longer qualified for such care. The same notice advised her that she would have to move to another nursing home, an intermediate care facility (ICF), to receive the level of care to which the State believed she should be downgraded. Green Valley provides ICF care, and in fact the bed occupied by Ms. Linton was dually certified for Medicaid purposes for provision of both SNF and ICF

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[1]This case is related to Doe v. Mid South Nursing Homes, Inc., et al, Civil Action No. 3-87-0760. For a summary of that litigation, see Report and Recommendation of the Magistrate, March 18, 1988 at 31-32.

levels of care. However, Green Valley was unwilling to care for Ms. Linton at an ICF level of reimbursement. The nursing home, which had directed the State to certify only part of its ICF beds as available to Medicaid patients, reserved the right to decertify the plaintiff's bed for Medicaid ICF participation. This decertification would have compelled the plaintiff's involuntary transfer to another facility.

On December 11, 1989, plaintiff Belle Carney, an 89 year old black woman, requested intervention. She had been diagnosed in July 1987 as requiring nursing home treatment due to Alzheimer's disease, however, no nursing home placement was found for her. Plaintiff Carney asserts that the State's limited bed certification policy, which the State refers to as distinct part certification, creates an artificial restriction on the number of available Medicaid beds and that it fosters discrimination against Medicaid patients by nursing homes. Plaintiff Carney's health deteriorated over a period of several months as she was moved from one inadequate placement to another. Finally, Carney's condition declined to the point that she required emergency hospitalization. Carney filed a motion to intervene at this time, and the Court affirmed the Magistrate's determination that plaintiff Carney possessed the requisite standing.

Title XIX of the Social Security Act, 42 U.S.C. § 1396 et seq. authorizes the expenditure of federal funds to enable states to furnish medical assistance to indigent individuals who are aged, blind or disabled, or who are members of families with dependent children. Tennessee participates in Title XIX for the purpose of operating such a medical assistance program ("Medicaid"), pursuant to T.C.A. § 71-5-101 [previously § 14-23-101 et seq.] Approximately, seventy per cent of the cost of the Tennessee Medicaid program is paid by the Health Care Financing Administration (HCFA) of the United States Department of Health and Human Services. In return for receipt of federal subsidies, the State of Tennessee is required to administer its Medicaid program in conformity with a state plan which satisfies the requirements of Title XIX and regulations promulgated pursuant

thereto, and which has been submitted to, and approved by the Secretary of Health and Human Services. 42 U.S.C. §§ 1396, 1396a.

Under the terms of Tennessee's approved State Medicaid plan, and pursuant to T.C.A. § 71-5-104, the Tennessee Department of Health and Environment (TDHE) is the single state agency responsible for administration of the Medicaid program. See 42 U.S.C. § 1296(a)(1) and (5). (1082 and Supp. 1987). The Department is administered under the direction of the defendant Commissioner.

Tennessee's Medicaid program covers nursing home treatment at both the intermediate care and skilled nursing levels of services. ICF services, as defined in 42 U.S.C. § 1396d(c) and (d), include institutional, health-related services above the level of room and board, but at a level of care below that of hospital or SNF care. See also 42 C.F.R. § 440.150. SNF care consists of institutional care above the level of ICF services but below the level of a hospital. 42 U.S.C. § 1296d(i); 42 C.F.R. § 440.40.

An individual's eligibility for coverage under the Tennessee Medicaid Program is determined on the basis of certain personal characteristics relating to need such as old age, disability or blindness, and on the basis of the person's indigency, measured by certain State and federal financial standards. To obtain Medicaid coverage for nursing home care the patient must first establish financial eligibility and then meet additional medical need requirements demonstrating eligibility for ICF or SNF services. The medical requirements, established by the State pursuant to 42 U.S.C. § 1396a(a)(30), are for the purpose of safeguarding against unnecessary treatment.

In order to determine a patient's medical eligibility, Tennessee requires that each Medicaid recipient's need for admission to a nursing home be evaluated prior to the recipient's admission to the institution or, if the patient has already been admitted, prior to an authorization of Medicaid reimbursement for his or her care. See

42 C.F.R. §§ 456.271 and 456.372; and THDE [*sic*] §§ 1200-13-1-10 and 1200-13-1-13. This process is referred to an the pre-admission evaluation (PAE) process.

Once a patient has been admitted to a nursing home, his or her continued need for ICF or SNF care is annually reviewed by State Medicaid officials pursuant to a process referred to as utilization review which is required pursuant to 42 U.S.C. § 1396a(a)(30).

Pursuant to 42 U.S.C. § 1396a(a)(33), TDHE is responsible for establishing a plan, consistent with federal regulations, for:

> (A) ... the review by appropriate personnel of the appropriateness and quality of care and services furnished to recipients of medical assistance ...; and [for]
>
> (B) the function of determining whether institutions and agencies meet the requirements for participation in the program [as health care providers] ...

42 U.S.C. § 1296a(a)(3); see also 42 C.F.R. § 442.

Federal law authorizes State agencies who perform this survey and certification function to certify facilities for either SNF or ICF reimbursement. Such certification may be of a "distinct part of an institution." See 42 U.S.C. § 1396x (federal Medicare statute recognizing "distinct part" certification) and 42 U.S.C. § 1396a(a)(28) (applying "distinct part" certification to Medicaid SNF certification). The Department of Health and Human Services, Health Care Financing Administration in its "Medicare/Medicaid State Operations Manual" has defined "distinct part" certification as follows:

> The term "distinct part" denotes that the unit is organized and operated to give a distinct type of care within a larger organization which otherwise renders other types or levels of care. "Distinct" denotes both

> organizational and physical distinctness. A distinct part SNF must be physically identifiable and be operated distinguishably from the rest of the institution. It must consist of all the beds within that unit such as a separate building, floor, wing or ward. Several rooms at one end of a hall or one side of a corridor may be accepted as a distinct part SNF.
>
> In each case, however, all the patients of the distinct part would have to be located in units which are physically separate from those units housing all other patients of the institution. Various beds scattered throughout the institution would not comprise a unit operated distinguishably for purposes of being certified as a SNF.

HCFA Medicare/Medicaid State Operations Manual, § 2110, Exhibit 19 (emphasis added) [hereinafter State Operations Manual].

On September 7, 1989 the Health Care Financing Administration (HCFA) of the Department of Health and Human Services, which administers the Medicare and Medicaid programs at the federal level issued an interim final rule revising current Medicare regulations relating to "swing beds." Swing beds are beds operated by acute care hospitals but providing intermediate or skilled level nursing facility, rather than inpatient hospital, care.

The new interim rule is irrelevant to this litigation. However, the supplementary information which accompanies the regulation provides an instructive reaffirmation of federal policies on "distinct part" certification under Medicaid. The explanatory material provided by HCFA confirms that Tennessee's lassiez faire approach to certifying any beds, and only those beds, which a nursing home operator directs it to certify, is squarely at odds with federal "distinct part" requirements:

> Hospitals participating in Medicare and Medicaid, in addition to providing an inpatient hospital level of care,

> may also provide SNF or ICF levels of care through the establishment of a separately participating "distinct part" unit. Among health, safety and other requirements, *a distinct part SNF or ICF must be an entire separately identifiable unit consisting of all the beds within that unit (such as, a separate building, floor, wing, or corridor)*. A distinct part SNF or ICF unit is paid as an entity separate from the rest of the institution [54 Federal Register 37, 270 (September 7, 1989)] (emphasis added).

Furthermore, by regulation, an ICF distinct part can only be certified as "part of a facility other than an intermediate care facility [and] if the distinct part:

> (1) Meets all requirements for an intermediate care facility;
> (2) Is an identifiable unit, such as an entire ward or contiguous ward, a wing, floor, or building;
> (3) Consists of all beds and related facilities in the unit;
> (4) Houses all recipients for whom payment is being made for intermediate care facility services ...;
> (5) Is clearly identified; and
> (6) Is approved in writing by the survey agency.

42 C.F.R. § 440.150(d) (emphasis added).

Finally, an ICF distinct part must "[house] all ICF ... residents in the institution", see State Operations Manual, supra at 7, and a facility is restricted in its ability to change the size of the certified distinct part unit during an accounting year. U.S. Dept. of Health, Education and Welfare, Office of Nursing Home Affairs, State Survey Agency Long Term Care Manual, pp. 38-39 [Exhibit 30, pp. 112-13].

A. The Tennessee Medicaid Program

Tennessee participates in the federal Medicaid program to provide medical assistance to those recipients who are determined to be eligible to receive such assistance in accordance with the

requirements of Title XIX of the Social Security Act. See Tenn. Code Ann. § 71-5-102. TDHE and its Commissioner are designated by statute as the administering agency to implement the State Medicaid plan. Tenn. Code Ann. § 71-5-704. The types of medical assistance that are provided under the Tennessee Medicaid program include, among others, services by skilled nursing home facilities and intermediate care facilities. Tenn. Code Ann. § 71-5-107. TDHE also acts as the State licensing agency for nursing homes or long term care facilities and certifies such facilities for Medicaid. TDHE inspects long term care facilities to ascertain that they are incompliance with State regulation and federal law.

Furthermore, under the Tennessee Medicaid program, TDHE standards for admission to a SNF or ICF are as follows:

(1) Generally admissions to the facilities should be in the order that the referral was received by the facility as shown on the wait list.

(2) Documentation justifying deviation from the order of the wait list must be maintained for inspection by the Department. Deviation may be based upon medical need, or valid, consistent facility administrative policy.

(3) In the event of deviation as a result of medical need, documentation should include a narrative description of medical circumstances showing the exigent or particular need of the applicant.

Docket Entry No. 22, Exhibit 2. Also, for certification of nursing homes under the Medicaid program, there are the requirements that:

1. All residents are admitted to the facility without discrimination regarding race, color or national origin.

2. The nursing home utilizes its referral sources in a manner which assures an equal opportunity for admission to

persons without regard to race, color, or national origin in relation to the population of the service area or potential service area.

Tennessee has previously had a "Medicaid Bed Management Program" which represents an attempt to place a percentage limitation on the number of available Medicaid beds in nursing homes. Federal auditors recommended that this policy be discontinued, and Tennessee abolished this program on October 1, 1985.

Plaintiffs challenge what they refer to as an unwritten limited bed certification policy. Defendants assert that this policy is instead simply Tennessee's version of distinct part certification. The Court finds, however, that the Tennessee policy varies markedly from federal "distinct part" certification.

Perhaps the most fundamental difference between Tennessee's limited bed certification policy and federal "distinct part" certification is to be found in the different purposes served by the respective policies. Federal distinct part certification is intended to accommodate the delivery of qualitatively different types of health care within the same facility. Tennessee's policy, however, appears to serve the interests of nursing homes who wish to participate in the Medicaid program while also maintaining a separate private pay facility offering the same type of care.

Consequently, the federal distinct part and State "limited bed" certification policies diverge sharply in their characteristics and implementation. Although federal regulations permit a distinct part ICF to be certified only in facilities other than ICFs, Tennessee will, at the provider's instructions, certify a limited component of beds in a facility which provides the same ICF level of care in all beds, certified and non-certified alike. Thus, under State policy the certified portion of a facility need not house all ICF residents in the institution as required by the State Operations Manual.

In contrast to federal requirements, the State certifies beds which are not in a separately administered unit of a facility, but are instead part of a wing or hallway that also contains non-certified beds. See Damall Testimony, Transcript pp. 102-108. At the request of a nursing home facility, even a single bed in a semi-private room will be "spot certified" although it might be in a unit which is otherwise made up entirely of non-certified beds providing the same level of care. While the State asserts it generally engages in spot certification only in the interest of a patient who has exhausted his or her private resources and to prevent a transfer, the Court finds that the facility would not need to request spot certification if, as is required by federal law, the entire ICF portion of a single institution were Medicaid certified.

Federal Medicaid law mandates that states set their Medicaid payments to nursing homes at levels which are "reasonable and adequate to meet the costs which must be incurred by efficiently and economically operated facilities in order to provide care and services in conformity with applicable State and Federal laws, regulations and quality and safety standards ..." 42 U.S.C. § 1396(a)(13)(A).[2]

By contrast, private pay rates are set by the market, a market in which there are more patients seeking care than there are beds to accommodate them. There are waiting lists to gain admission to nursing homes throughout Tennessee. As a result of this situation, unregulated private pay rates are substantially higher than Medicaid payments, and nursing home operators prefer private pay patients. Tennessee's present certification program allows nursing home operators to give preference to private pay patients by reserving for their exclusive use beds which are, due to lack of certification, unavailable to Medicaid patients.

The effects of the limited bed certification policy take a

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[2]The adequacy of Medicaid reimbursement rates, however, is not at issue here.

number of different forms. The policy leads to disruption of care and displacement of Medicaid patients after they have been admitted to a nursing home. Such displacement often occurs when a patient exhausts his or her financial resources and attempts transition from private pay to Medicaid. In this situation, a patient who already occupies a bed in a nursing home is told that his or her bed is no longer available to the patient because he or she is dependent upon Medicaid. furthermore, displacement also occurs when patients at the SNF level who are covered by Medicare, the Veterans Administration or private insurance, transfer to the ICF level of care where they are dependent on Medicaid because their prior coverage does not cover intermediate care. Involuntary transfers are triggered on other occasions when a patient already on Medicaid at an SNF level of reimbursement is reclassified to an ICF level of care.

Despite the State's assertions that complaints of improper or involuntary transfers have been rare, and when such complaints have been raised, they have been promptly resolved, the Court finds that the limited bed certification policy has caused widespread displacement. Furthermore, the Court finds that the patients and their families faced with the displacement situation are often under the impression that the State itself has caused the displacement and is unlikely to seek help from the State against the nursing home who appears to be "on their side." The Court is persuaded by the depositions, affidavits and exhibits concerning the severe impact of the limited bed certification policy. Finally, the Court is mindful of the Medicaid eligibility rules which allow eligibility for relatively more affluent patients already residing in nursing homes than those seeking initial admission. This phenomenon combined with the limited bed certification policy often renders the poorest and most medically needy Medicaid applicants unable to obtain the proper nursing home care.

B. Disparate Impact on Minorities

The Court finds that the plaintiff has established by a preponderance of the evidence that the Tennessee Medicaid

program does have a disparate and adverse impact on minorities. Because of the higher incidence of poverty in the black population, and the concomitant increased dependence on Medicaid, a policy limiting the amount of nursing home beds available to Medicaid patients will disproportionately affect blacks.

Indeed, while blacks comprise 39.4 percent of the Medicaid population, they account for only 15.4 percent of those Medicaid patients who have been able to gain access to Medicaid-covered nursing home services. In addition, testimony indicates that the health status of blacks is generally poorer than that of whites, and their need for nursing home services is correspondingly greater. Finally, such discrimination has caused a "dual system" of long term care for the frail elderly: a statewide system of licensed nursing homes, 70 percent funded by the Medicaid program, serves whites; while blacks are relegated to substandard boarding homes which receive no Medicaid subsidies.

CONCLUSIONS OF LAW

A. The Challenged Policy Violates Federal Medicaid Statutes and Regulations Relating to Nursing Home Survey and Certification

The objective of the nursing home survey and certification process established by 42 U.S.C. § 1396a(a)(33) is the protection of nursing home patients and enforcement of their statutory entitlement to high-quality care. See Estate of Smith v.Heckler, 747 F.2d 583 (10th Cir. 1984). Tennessee's limited bed certification policy subverts the accomplishment of this statutory purpose and transforms the survey and certification process into an instrument for denying patients' access to the medically necessary care to which they are entitled.

The State's policy offends not only the purpose of the federal statute, but also its literal language. Subsection (B) of 42 U.S.C § 1396(a)(33) requires the State Medicaid agency to determine "whether institutions and agencies" -- not parts thereof -- meet the

requirements for participation in the Medicaid program. The State must certify the facility in its entirety if it meets federal criteria, or deny certification if it has "good cause." 42 C.F.R. § 442.12. The State cannot, however, withhold certification of part of the facility.

Although Title XIX does not protect recipients' right to remain in unqualified nursing homes at Medicaid's expense, it does confer:

> the right to choose among a range of qualified providers, without government interference. By implication, it also confers an absolute right to be free from government interference with the choice to remain in a home that continues to be qualified. O'Bannon v. Town Court Nursing Center, 447 U.S. 773 (1980) (emphasis in original).

Tennessee's policy of limiting the number of beds certified in qualified facilities constitutes precisely the type of interference proscribed by the statute.

In its administration of Tennessee' Medicaid program, the Tennessee Department of Health and Environment must "comply with requirements imposed by [Title XIX of the Social Security] Act and by the Secretary of Health and Human Services." Atkins v. Rivera, 477 U.S. 154, 157 (1986). It is of course well-settled that, in construing a complex statute such as Title XIX, deference should be accorded to interpretations of the law adopted by agencies charged with their administration. Such deference must be accorded, not only to formally promulgated regulations, but also other official pronouncements of agency policy such as manuals and administrative rulings. Smith v. Miller, 655 F.2d 172, 179 (7th Cir. 1981).

While there are no prior judicial decisions on point, a consistent line of administrative rulings by HCFA holds that a policy of certifying less than all of a Medicaid-participating

facility's beds is contrary to federal law and regulations. See Memorandum of August 22, 1983 from HCFA's Director, Bureau of Eligibility, Reimbursement and Coverage, to the HCFA Regional Administrator of Region IV, which includes Tennessee [Exhibit 6]; letter from HCFA Administrator Carolyn K. Davis to B.F. Simmons, dated May 29, 1981, disallowing a Mississippi proposal to impose a statewide cap on the total number of Medicaid-certified beds [Exhibit 7]; HCFA Decision dated 1/14/85, disapproving Mississippi State Plan Amendments 84-6, 84-7, and 84-8 with attached Hearing Officer's Recommended Decision [Exhibit 47]; Letter of 1/27/84 from Carolyn Davis to John LaFara disapproving Montana State Plan Amendments 83-19 and 83-20 [Exhibit 48]; HEFA Notice of Hearing on disapproval of Mississippi State Plan Amendment, 47 Fed. Register 8093-8094 (2/24/82); HCFA Notice of Hearing on disapproval of South Carolina State Plan Amendment, 47 Fed. Register 10, 295 (3/10-82) [Exhibit 50]; HCFA Notice of Hearing on disapproval of Missouri State Plan Amendments, 48 Fed. Register 44,930-44,931 (9/30/83) [Exhibit 51]; and HCFA, "Target Area Report: TDHE Medicaid Bureau Administration of Long Term Care Services" (4/15/85 - 5/2/85) [Exhibit 60]. Significantly, this body of authority includes HCFA's recommendation that Tennessee abolish its former Medicaid Bed Management Program, for reasons that are equally applicable to the current limited bed certification policy. The State contends that HCFA's concern with respect to limited bed policies has been primarily directed toward percentage or numerical caps on the number of beds. The Court finds that Tennessee's current policy has the same purpose and problems of the so-called percentage limitations and thus violates the HCFA policy.

Although TDHE has never reduced its policy to writing or submitted it to HCFA for approval, TDHE contends that its policy is consistent with federal "distinct part" regulations and HCFA directives. The Court finds that the State's policy simply does not meet the requirements of "distinct part" certification as enumerated in federal regulations and HCFA directives.

The State also defends the limited bed certification policy on the basis that it is consistent with the voluntary nature of provider participation in the Medicaid system and warns that if the policy is eliminated, a number of nursing home facilities who presently participates in Medicaid-covered services are likely to opt out of the system. See Defendant's Proposed findings of Fact and Conclusions of law, pp. 14-17. It is the Court's opinion that even if some Tennessee nursing home facilities "opt out", the weight of the evidence establishes that the vast majority of nursing homes are dependent on Medicaid funding in order to operate and are likely to continue to participate in the system. See Deposition of M. Catherine Hawes, Plaintiff's Exhibit 1, January 27, 1989. furthermore, of those nursing home facilities that choose not to participate in Medicaid, many are retirement communities in which nursing home care is paid by the resident's entrance fee, while others tend to be smaller facilities not meeting other Medicaid regulations such as fire and safety standards. Thus, just as compliance with Medicaid fire safety standards, quality of care standards, and patient protection standards involves some cost or inconvenience, so too does compliance with basic Medicaid requirements. Nonetheless, the Court shall conduct a further hearing to consider as part of the overall formulation of an appropriate remedy, what prophylactic steps, if any, should be taken to prevent or mitigate provider attrition.

B. Plaintiffs' Claims Under Title VI of the Civil Rights Act of 1964

Title VI of the Civil Rights Act of 1964 provides, in relevant part:

> No person in the United States shall on the ground of race, color or national origin ... be subjected to discrimination under any program or activity receiving Federal financial assistance.

42 U.S.C. § 2000d. Regulations under Title VI provide that a state in its administration of the federally funded program can not:

> ...directly or through contractual or other arrangements, utilize criteria or methods of administration which have the effect of subjecting individuals to discrimination because of their race, color, or national origin, or have the effect of defeating or substantially impairing accomplishment of the objectives of the program as respect individuals of a particular race, color or national origin.

45 C.F.R. § 80.3(b)(2).

The Supreme Court decisions that interpret Title VI proscribe state policies and practices that have racially disparate and discriminatory effects. In Guardians Assn. v. Civil Service Commn., 463 U.S. 582 (1983), The Supreme Court held that Title VI reaches unintentional disparate impact discrimination as well as deliberate racial discrimination. However, unless discriminatory intent is shown, declaratory and injunctive relief should be the only available remedies for Title VI violations. However, as explained in the Supreme Court's subsequent decision in Alexander v. Choate:

> In Guardians, we confronted the question whether Title VI of the Civil Rights Act of 1964, 42 U.S.C. § 2000d et seq., which prohibits discrimination against racial and ethnic minorities in programs receiving federal aid, reaches both intentional and disparate-impact discrimination. No opinion commanded a majority in Guardians, and Members of the Court offered widely varying interpretations of Title VI. Nonetheless, a two-pronged holding on the nature of the discrimination proscribed by Title VI emerged in that case. First, the Court held that Title VI itself directly reached only instances of intentional discrimination. Second, the Court held that actions having an unjustifiable disparate impact on minorities could be redressed through agency regulations designed to implement the purposes of Title VI. In essence, then, we held that Title VI had delegated

> to the agencies in the first instance the complex determination of what sorts of disparate impacts upon minorities constituted sufficiently significant social problems, and were readily enough remediable, to warrant altering the practices of the federal grantees that had produced those impacts. [footnotes omitted].

469 U.S. 292-94.

The plaintiffs have shown that the defendants' limited bed certification policy has a disparate impact on racial minorities in Tennessee. The burden of proof next falls upon the defendants to show that the disparate impact is not unjustifiable. The defendants state that the "self-selection preferences" of the minorities, based upon the minorities reliance upon the extended family, lack of transportation, and fear of institutional care, adequately explain the disparate impact. See, Defendants' Proposed Findings of Fact and Conclusions of Law, at p. 20. This explanation, however, is not sufficient justification for minority underrepresentation in nursing homes. Therefore, the defendants have failed to meet their burden of proof under Alexander v. Choate.

Because past racial discrimination was the product "of invidious animus ... rather than thoughtlessness and indifference", Alexander v. Choate, 469 U.S. at 296, statistical evidence of disparate racial impact of state policies in federally funding programs can establish liability under Title VI for declaratory and injunctive relief, if the agency has not addressed them. Guardians Assn. v. Civil Service Commn. of New York, 463 U.S. at 592-93. See also Weathers v. Peters Realty, 499 F.2d 1197, 1201-02 (6th Cir 1974). The Court is convinced that the Tennessee limited bed certification policy has had a disparate adverse impact on black Medicaid recipients in Tennessee. Furthermore, provider agreements which permit providers to serve Medicaid patients in only a limited number of their available beds are invalid under Medicaid regulations codified at 42 C.F.R. § 442.12(d)(2):

> A provider agreement is not a valid agreement for

purposes of this part, even though certified by the State survey agency, if the facility fails to meet the civil rights requirements set forth in 45 C.F.R. Parts 80, 84, and 90.

The Court recognizes that under Title VI, deference is accorded to the Title VI administrative agency to cure the discriminatory effects of the particular program. To be sure, THDE employs Ms. Beverly Bass as a director to monitor Title VI compliance. However, even Bass concedes that under the TDHE certification policy black Medicaid recipients are displaced or denied admission to nursing homes. Further, it is noteworthy that the Bed Management Program that was instituted in 1981, was not repealed as TDHE policy until October 13, 1987. Prior TDHE studies identified the status of minority citizen in Tennessee's Medicaid Program and the reasons for lack of minority participation. Yet, despite these studies, the Commissioner implemented a policy that fosters and continues the egregious status of minority Medicaid patients within the program. In these circumstances, continued deference to the administrative agencies is inappropriate. To cure the effects of this policy, judicial intervention is necessary. To accomplish this, the Court ORDERS the Commissioner, in consultation with the HCFA, to submit a plan for court approval that will redress the disparate impact upon eligible minority Medicaid patients' access to qualified nursing home care due to the THDE certification policy and the State's past noncompliance with Title VI.

C. Other Statutory Requirements

In addition to violating the federal Medicaid statutes, regulations, and HCFA policy directives relating to nursing home survey and certification, the Court holds that the challenged limited bed certification policy also violates the following statutes and regulations:

(1) 42 C.F.R. § 431.10(e)(1) which provides that TDHE, as the single state Medicaid agency:

must not delegate, to other than its own officials, authority to –

(i) Exercise administrative discretion in the administration or supervision of the plan, or
(ii) Issue policies, rules and regulations on program matters.

(2) 42 U.S.C. § 1396a(a)(23) and 42 C.F.R. § 431.51(a) which provides that TDHE must administer the program in a manner which ensures "that recipients may obtain services from any qualified Medicaid provider;"

(3) 42 C.F.R. § 440.240 which requires that the agency must ensure compliance with State Medicaid Plan provisions which mandate

(a) that the services available to any categorically needy recipient under the plan are not less in amount, duration and scope than those services available to a medically needy recipient; and

(b) that the services available to any individual in the following group are equal in amount, duration and scope for all recipients within the group:

(1) The categorically needy;
(2) A covered medically needy group;

(4) the utilization control mechanism pursuant to 42 U.S.C. § 1396(a)(30) which safeguards against unnecessary utilization of medical care and services by causing increased illness, transfer trauma and displacement;

(5) 42 C.F.R. § 440.230(b) which requires that State limitations of services covered by Medicaid must be such that those services, including nursing home call, are adequate in amount, scope, and duration to

reasonably achieve their purpose of meeting the medical needs of recipients;

(6) 42 U.S.C. § 1396a(a)(19) which imposes on Tennessee a duty to:

> provide such safeguards as may be necessary to assure that eligibility for care and services under the [Medicaid] plan will be determined, and such care and services will be provided in a manner consistent with simplicity of administration and the best interests of the recipients;

(7) 42 C.F.R. § 447.204 which requires that covered services, including nursing home care, must be available to the extent that those services are available to the general population, and

(8) 42 U.S.C. § 1396a(a)(8) which requires states to ensure that medical assistance will "be furnished with reasonable promptness to all eligible individuals." The limited be policy has caused Medicaid patients to experience extended delays and waiting lists in attempting to gain access to long term nursing home care.

CONCLUSION

In light of the foregoing reasons, the Court declares the State's limited bed certification policy invalid. A further hearing shall be scheduled for the purpose of formulating an appropriate remedy.

SUMMARY

Plaintiffs challenge the State of Tennessee's practice of allowing nursing homes in Tennessee to certify less than all of their beds as available to Medicaid patients. The Court hereby

declares such policy in violation of Title XIX of the Social Security Act, 42 U.S.C. § 1396 et seq., and Title VI of the Civil Rights Act of 1964, 42 U.S.C. § 2000d. The Court hereby ORDERS a further hearing to determine an appropriate remedy, and ORDERS the Commissioner, in consultation with HCFA, to submit a plan for Court approval that will redress the disparate impact on minority Medicaid patients' access to qualified nursing home care.

An Order will be entered in accordance with the reasoning set forth in this Memorandum.

Entered this the 20th day of April, 1990.

/S/
UNITED STATES DISTRICT JUDGE

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DEPARTMENT OF HEALTH AND ENVIRONMENT–1200
Office on Civil Rights Compliance

STATEMENT OF NECESSITY REQUIRING PUBLIC NECESSITY RULES

The attached rules are for the purpose of implementing a Federal Court Order in the case of *Linton v. Commissioner*, M.D., Tenn, No. 3-87-0941 (July 5, 1990). Pursuant to *T.C.A. § 4-5-209*, the Department is authorized to promulgate public necessity rules for the purpose of effectuating a Court Order.

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TENNESSEE DEPARTMENT OF HEALTH AND ENVIRONMENT – 1200
Office on Civil Rights Compliance

CHAPTER 1200-24-3
CIVIL RIGHTS COMPLIANCE PENALTY PROGRAM RULES AND REGULATIONS

NEW RULES

TABLE OF CONTENTS

1200-24-3-.01 Purpose
1200-24-3-.02 Definitions
1200-24-3-.03 Sanctions
1200-24-3-.04 Types of Civil Penalties
1200-24-3-.05 Repeated and Maximum Penalties
1200-24-3-.06 Hearings and Appeals

1200-24-3-.01 PURPOSE.

The purpose of these rules is to provide regulatory guidance for assessing civil penalties pursuant to *T.C.A. § 68-1-113*. The rules apply only to nursing homes as defined at *T.C.A. § 68-11-201* and licensed by the department for the purpose of assisting in enforcing compliance with Title VI of the Civil Rights Act of 1964, as amended and requirements of *Linton v. Commissioner*, M.D. Tenn, No. 3-87-0941.

Authority: *T.C.A. §§ 4-3-1803(1), 68-1-103(b), 68-1-113 and 4-5-209.*

1200-24-3-.02 DEFINITIONS.

(1) *Health Care Facility* -- Any facility licensed under the authority of the Board for Licensing Health Care Facilities as defined in *T.C.A. § 68-11-201*.

(2) *Civil Rights* -- Personal and individual rights guaranteed by the federal or state constitution and/or federal or state statute.

(3) *Commissioner* -- The Commissioner of the Tennessee Department of Health and Environment or his designated representative.

(4) *Department* -- Tennessee Department of Health and Environment.

(5) *Title VI* -- Title VI of the Civil Rights Act of 1964, as amended (42 USC § 2000d).

(6) *Minority* -- Persons who fall within the following categories: Black, not of Hispanic origin; Hispanic; American Indian; Alaskan Native; Asian or Pacific Islander.

(7) *Discrimination* – Any act, policy, practice, or procedure which results in different treatment based on race, color, national origin or method of payment that impacts adversely upon minorities and others protected under Title VI of the Civil Rights Act of 1964.

(8) *Office on Civil Rights Compliance (OCRC)* – The administrative, regulatory and enforcement unit established within the Department of Health and Environment charged with the responsibility of monitoring and investigating complaints related to civil rights compliance of facilities regulated by the Board.

Authority: T.C.A. §§ 4-3-1803(1), 68-1-103(b), 68-1-113 and 4-5-209.

1200-24-3-.03 SANCTIONS.

Pursuant to *T.C.A. § 68-1-113*, the Commissioner of the Department of Health and Environment shall have the authority to impose civil penalties upon deficient health care facilities licensed as nursing homes. Based upon the investigation of the Office on Civil Rights Compliance and the severity of the discriminatory practice, the Commissioner may impose civil penalties as provided in this section. Civil penalties may be assessed in minimum and maximum amounts as follows:

(a) Type I civil penalties may be assessed in the amount of not less than three thousand five hundred dollars ($3,500) and not more than five thousand dollars ($5,000);

(b) Type II civil penalties may be assessed in the amount of not less than one thousand five hundred dollars ($1,500) and no more than three thousand five hundred dollars ($3,500);

(c) Type III civil penalties may be assessed in the amount of not less than five hundred dollars ($500) and no more than one thousand five hundred dollars ($1,500).

Authority: T.C.A. §§ 4-3-1803(1), 68-1-103(b), 68-1-113 and 4-5-209.

1200-24-3-.04 TYPES OF CIVIL PENALTIES.

(1) A Type I civil penalty may be assessed if the health care facility engages in discrimination which impacts negatively on the health, safety and welfare of multiple minority patients. Examples of practices which may lead to the imposition of a Type I civil penalty are:

(a) Denying persons admission to the facility on the basis of race, color, creed and national origin, or method of payment as provided by state or federal law, rules or regulations;

(b) Transferring multiple patients from one room to another on the basis of racial or source of payment considerations (except for affirmative action remedies which pose no risk to patients).

(c) Clustering patients on the basis of race, color, creed or national origin or source of payment on specific floors, sections, or wings of the facility.

(d) Not admitting applicants to a facility on a first come first serve basis as required by state or federal laws, rules or regulations.

(e) Retaliating against residents or staff because of complaints made to the Department.

(2) A Type II civil penalty may be assessed if the Health Care Facility utilizes a policy or procedure that is likely to be detrimental to a patient and the facility refuses to correct the violation. Examples of practices which may lead to the imposition of a Type II civil penalty are:

(a) Denial of admission of a single individual on the basis of race, creed, color or national origin or method of payment as provided by state or federal law, rules or regulations;

(b) Assigning a room or transferring a single individual on the basis of race, creed, color or national origin or method of payment contrary to state or federal law, rules or regulations.

(c) Providing segregated services, e.g., beauty and barber shops, dining rooms, lounges.

(d) Denial of an individual the opportunity to participate on a planning or advisory board on the basis of race, color, national origin, or method of payment as required by state or federal law, rules or regulations.

(e) Retaliating against an individual resident or staff member because of complaints made in good faith to the Department.

(3) A Type III civil penalty may be assessed for deficiencies that do not directly involve a specific individual but violate state and federal law, rules or regulations. Examples which may lead to a Type III civil penalty may include:

(a) Failure to develop an acceptable plan of correction within the time required.

(b) Failure to make available all data and pertinent information requested by OCRC.

(c) Failure to notify referral sources and the minority community that services are provided in a non-discriminatory manner as required by state or federal law, rules or regulations.

(d) Failure to display in prominent places the required compliance statements as required by state or federal law, rules or regulations.

(e) Failure to make adequate or appropriate notification of the facility's commitment to providing services in a non-discriminatory manner as required by state or federal law, rules or regulations.

(f) Failure to include a non-discriminatory statement in all vendor contracts and brochures and other information distributed to the public as required by state or federal law, rules or regulations.

Authority: T.C.A. §§ 4-3-1803(1), 68-1-103(b), 68-1-113 and 4-5-209.

1200-24-3-.05 REPEATED AND MAXIMUM PENALTIES.

(1) Penalties may be imposed simultaneously for multiple and distinct civil rights violations.

(2) If corrective action is not accomplished within a time period approved by OCRC a civil penalty with the initial amount may be imposed.

Authority: T.C.A. §§ 4-3-1803(1), 68-1-103(b), 68-1-113 and 4-5-209.

1200-24-3-.06 HEARINGS AND APPEALS.

Any facility that is aggrieved by action of the Commissioner pursuant to these rules, may, within thirty (30) days of receipt of a penalty assessment, request a hearing before the Commissioner or his designee. All hearings shall be conducted pursuant to the Uniform Administrative Procedures Act, Title 4, Chapter 5, Part 3.

Authority: T.C.A. §§ 4-3-1803(1), 68-1-103(b), 68-1-113 and 4-5-209.

The public necessity rules set out herein were properly filed in the Department of State on the 16th day of August, 1990, and will be effective from the date of filing for a period of 120 days. The Public Necessity Rules will remain in effect through the 14th day of December, 1990.

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TENNESSEE DEPARTMENT OF HEALTH AND ENVIRONMENT – 1200
Division of Medicaid

STATEMENT OF NECESSITY REQUIRING PUBLIC NECESSITY RULES

I am herewith submitting proposed amendments to chapter 1200-13-1, the General Rules of the Medicaid program, for promulgation under the public necessity provision of the Uniform Administrative Procedures Act.

The proposed amendments concern changes to the nursing home admission "wait list" and to nursing home provider termination procedures. The rule requires the provider to have a single "wait list" for all applicants requesting admission to that facility and specifies the information that must be included on the "wait list". The rule also specifies the order in which applications must be selected from the "wait list" for admission to the nursing home. It also specifies procedures for voluntary termination by providers and specifies restrictions on future participation for those providers who are involuntarily decertified by the Department.

This amendment effectuates a court order.

Manuel Martins
Assistant Commissioner for Medicaid
Tennessee Department of Health and Environment

TENNESSEE DEPARTMENT OF HEALTH AND ENVIRONMENT – 1200
Division of Medicaid

CHAPTER 1200-13-1
GENERAL RULES

AMENDMENTS

Rule 1200-13-1-.01 DEFINITIONS is amended by addition of new paragraphs (15) through (20) which shall read as follows:

(15) Applicant shall mean any person who seeks admission to a Long-term Care Facility and is not limited to those persons who have completed an official application or have complied with the Long-term Care Facility's preadmission requirements. The term shall include all persons who have affirmatively expressed an intent to be considered for current or future admission to the Long-term Care Facility or requested that their name be entered on any "wait list". Persons who only make casual inquiry concerning the Long-term Care Facility or its admission practices, who request information on these subjects, or who do not express any intention that they wish to be actively considered for admission shall not be considered applicants. All persons, whether applicants or non-applicants, who contact a Long-term Care Facility to casually inquire about the facility's services or admissions policies shall be informed by the facility of that person's right to apply for admission and be considered for admission on a non-discriminatory basis and in conformance with rule 1200-13-1-.08 and *T.C.A. § 68-11-910(b).*

(16) Medicaid Eligible shall mean a person who has been determined by the Tennessee Department of Human Services or the Social Security Administration to be financially eligible to have Medicaid make reimbursement for covered services.

(17) Long-term Care Recipient shall mean a person who has attained Medicaid eligible status and who is medically entitled. Long-term Care Recipient status is attained on the date for which both Medicaid eligible and medically entitled status coincide.

(18) Medically Entitled shall mean a person who has a Pre-Admission Evaluation (PAE) that has been certified by a physician and that has been approved by the Bureau of Medicaid.

(19) Involuntary transfer or discharge shall mean any transfer or discharge that is opposed by the resident or a representative of the resident. For purposes of compliance with the requirements of rule 1200-13-1-.05(18), a discharge or transfer is involuntary when the Long-term Care Facility initiates the action to transfer or discharge.

(20) Notice, when used in regulations pertaining to Long-term Care Facilities, shall mean notification that must be provided by the facility to "residents" or "applicants", and shall also include notification to the person identified in a PAE application as the resident's or applicant's designated representative and any other individual who is authorized by law to act on the resident's or applicant's behalf or who is in fact acting on the resident's or applicant's behalf in dealing with the Long-term Care Facility.

Rule 1200-13-1-.08 ADMISSIONS TO INTERMEDIATE CARE FACILITIES AND SKILLED NURSING FACILITIES is amended by deleting the title of the section and paragraphs (1) through (4) in their entirety, replacing them with a new title and new paragraphs (1) through (8) and renumbering existing paragraph (5) as paragraph (9). The new title and new paragraphs (1) through (8) shall read as follows:

1200-13-1-.08 ADMISSIONS TO LONG-TERM CARE FACILITIES.

(1) Each Long-term Care Facility participating in the medical assistance program must develop and consistently implement policies and procedures regarding its admissions, including the development and maintenance of a single wait list of persons requesting admission to those

facilities. This list must at a minimum contain the following information pertaining to each request for admission:

(a) The name of the applicant.

(b) The name of the contact person or designated representative other than the applicant (if any).

(c) The address of the applicant and the contact person or designated representative (if any).

(d) The telephone number of the applicant and the contact person or designated representative (if any).

(e) The name of the person or agency referring the applicant to the nursing facility.

(f) The sex and race of the applicant.

(g) The date and time of the request for admission.

(h) Reason(s) for refusal/non-acceptance/other-action-taken pertaining to the request for admission.

(i) The name and title of the Long-term Care Facility staff person taking the application for admission.

(j) A notation stating whether the applicant is anticipated to be Medicaid eligible at time of admission or within one year of admission.

(2) The wait list should be updated and revised at least once each quarter to remove the names of previous applicants who are no longer interested in admission to the Long-term Care Facility. Following three (3) contacts each separated by a period of at least ten (10) days, the Long-term Care Facility shall, consistent with the written notice

required in this section move an applicant to the end of the single admission list whenever an available bed is not accepted at the time of the vacancy, but the applicant wishes to remain on the admissions list. Applicants shall be advised of these policies at the time of their inquiry, and must be notified in writing, in a format approved by the department, when their name is removed from the list or moved to the end of the list. Such contacts shall be documented in the facility log containing the wait list. The date, time and method of each contact shall be recorded along with the name of the facility staff person making the contact, and the identity of the applicant or contact person contacted. The log of such contacts shall also summarize the communication between the facility staff person and the applicant or contact person.

(3) Each facility shall send written confirmation that an applicant's name has been entered on the wait list, their position on the wait list, and a notification of their right of access to the wait list as provided in paragraph (8) of these rules. This confirmation shall include at a minimum the date and time of entry on the wait list and shall be mailed by first class postage to the applicant and their designated representative (if any) identified pursuant to the requirements in paragraph (1) above.

(4) Each Long-term Care Facility participating in the medical assistance program shall admit applicants in the chronological order in which the referral or request for admission was received by the facility, except as permitted in paragraph (5) of this rule.

(5) Documentation justifying deviation from the order of the wait list must be maintained for inspection by the department. Inspection shall include the right to review and/or make copies of these records. Deviation may be based upon:

(a) Medical need, including, but not necessarily limited to, the expedited admission of patients being discharged from hospitals and patients who previously resided in a Long-term Care Facility at a different level of care, but who, in both cases, continue to require institutional medical services;

(b) The applicant's sex, if the available bed is in a room or a part of the facility that exclusively serves residents of the opposite sex;

(c) Necessity to implement the provisions of a plan of affirmative action to admit racial minorities, if the plan has previously been approved by the department;

(d) Emergency placements requested by the department when evacuating another health care facility or by the Adult Protective Service of the Tennessee Department of Human Services;

(e) Other reasons or policies, e.g., previous participation in a community based waiver or other alternative care program, when approved by the Medical Director of the Department's Bureau of Manpower and Facilities; provided, however, that no such approval shall be granted if to do so would in any way impair the department's or the facility's ability to comply with its obligations under federal and state civil rights laws, regulations or conditions of licensure or participation.

(f) If a Medicaid-eligible recipient's hospitalization or therapeutic leave exceeds the period paid for under the Tennessee Medicaid program for the holding of a bed in the facility for the resident and if the resident continues to require the services provided by the Long-term Care Facility, then the resident must be readmitted to the facility immediately upon the

first availability of a bed in the facility, consistent with paragraph (5)(b);

(g) Where, with the participation and approval of the department, expedited admission is approved for residents who are being displaced from another facility or its waiting list as a result of that facility's withdrawal from the Medicaid program.

(6) Telephone requests, whether on his or her own behalf or acting through another, requests admission or to be placed on a list of applicants awaiting admission, the information on the waiting list must be recorded and preserved.

(7) If an applicant, whether on his or her own behalf or acting through another, requests admission or to be placed on a list of applicants awaiting admission, the information on the waiting list must be recorded and preserved.

(8) Applicants (or their representative), Ombudsmen and appropriate state and federal personnel shall have access to the wait list when requested. Such access shall include the right to review and/or copy the wait list, and to be informed by telephone of their position on the wait list.

Rule 1200-13-1-.05 PROVIDERS is amended by addition of new paragraphs (15) through (18) which shall read as follows:

(15) Long-term Facilities who choose to voluntarily terminate their provider agreement may do so by notifying the department in writing of such intent.

(a) The effective date of the termination will be determined by the department. The notification must provide the following information:

1. The reason(s) for voluntary termination;

2. The names and Medicaid identification number of all Medicaid-eligible residents;

3. The name of the resident and name of the contact person for the resident (if any) for residents with an application for Medicaid eligibility pending;

4. A copy of the letter the facility will send to each resident informing them of the voluntary termination, and a copy of the letter to be sent to all Medicaid-eligible residents regarding this action;

5. A copy of the letter sent to all applicants on the wait list informing them of the facilities voluntary termination; and

6. Other information determined by the department as necessary to process the request for termination.

(b) The termination of the provider's involvement in Medicaid must be done in such a manner as to minimize the harm to current residents.

1. Residents who are currently Medicaid-eligible shall be informed, in a notice to be provided by the facility and approved by the department, that the facility has elected to withdraw from the Medicaid program. The notice shall inform the resident of the right to remain in the facility, under the supervision of the department, the Long-term Care Facility where they now reside will assist in locating a new placement and providing orientation and preparation for the transfer, in accordance with 42 U.S.C. S [*sic*] 1396r(c)(2)(C) and implementing regulations and guidelines, if any.

2. All other residents of the facility shall receive a separate notice informing them of the facility's intention to withdraw from the Medicaid program. The notice will be provided by the facility after having been first reviewed and approved by the department. The notice shall inform such residents that, should they become eligible for Medicaid coverage, they will be able to convert to Medicaid from their current source of payment and remain in the facility only during a period that ends June 30, 1991. They will not be eligible for Medicaid coverage of their care in the facility thereafter. Transfer of these residents shall be considered an involuntary transfer and shall comply with department regulations governing involuntary transfer or discharges.

   The same notice will caution these residents that, if they require care as Medicaid patients beyond June 30, 1991, they will have to transfer to another facility. The notice will also inform the residents that, when their present facility is no longer participating in the Medicaid program, certain legal rights and protections that apply to all residents (regardless of source of payment) in Medicaid facilities will no longer be available to those who remain in the Long-term Care Facility. Readers of the notice will be informed that, if they wish to transfer, or to have their names placed on wait lists at other facilities, the facility that is withdrawing form the program will assist them by providing preparation and orientation, under the supervision of the department, as required by 42 U.S.C. S [*sic*] 1396r(c)(2)(C) and implementing regulations and guidelines, if any.

3. Applicants whose names are on the facility's wait list will be notified by the facility, on a form that

has been reviewed and approved by the department, that the facility intends to withdraw from the Medicaid program. They will be cautioned that they will not be able to obtain Medicaid coverage for any care that they receive in the facility. The notice shall also inform them that certain legal rights and protections that apply to all residents (regardless of source of payment) in Medicaid-participating facilities will not be available in the Long-term Care Facility to which they have applied, once that facility has withdrawn from the Medicaid program.

Applicants will be informed in the notice that, if they wish to make application at other facilities, the withdrawing facility, under the supervision of the department, shall assist them in seeking placement elsewhere.

4. After June 30, 1991, or the date on which the last Medicaid-eligible resident is lawfully and appropriately transferred or discharged, whichever event occurs later, the Long-term Care Facility will be decertified and its Medicaid provider agreement terminated.

(c) Facilities who notify the department of their intent to voluntarily terminate Medicaid participation may rescind such notification within thirty (30) days of receipt of the notification by the department. Notice of voluntarily termination shall automatically become irrevocable after thirty (30) days unless department approval is obtained to waive this provision. Facilities which voluntary terminate their provider participation agreements shall not be permitted to participate in the Medicaid program for a minimum of two (2) years from the date of termination.

(16) Long-term Care Facilities may be involuntarily decertified by the department because of their failure to comply with the provisions of Medicaid General Rule, chapter 1200-13-1. Facilities that are involuntarily decertified shall not be permitted to participate in the Medicaid program for a minimum of five (5) years from the date of decertification.

(17) Long-term Care Facilities participating in the Medicaid program shall not as a condition of admission to or continued stay at the facility request or require:

(a) Transfer or discharge of a Medicaid-eligible resident because Medicaid has been or becomes the resident's source of payment for long-term care.

(b) Payment of an amount from a Medicaid-eligible resident in excess of the amount of patient liability determined by the Tennessee Department of Human Services.

(c) Payment in excess of the amount of patient liability determined by the Tennessee Department of Human Services from any resident who is financially eligible for medical assistance but who has not submitted a PAE for consideration or whose appeal rights for a denied PAE have not been exhausted.

(d) Any person to forego his or her right to Title XIX Medical Assistance benefits for any period of time.

(e) A third party (i.e. responsible party) signature, except as required of a court appointed legal guardian or conservator, or require payment of any kind by a third party on behalf of a Medicaid eligible individual.

(18) Long-term Care Facilities participating in the Medicaid program must comply with the following guidelines

regarding transfers, discharges and/or readmissions.

(a) Transfer and Discharge Rights - a Long-term Care Facility must permit each resident to remain in the facility and must not transfer or discharge the resident from the facility unless:

1. The transfer or discharge is necessary to meet the resident's welfare which cannot be met in the facility;

2. The transfer or discharge is appropriate because the resident's health has improved sufficiently so the resident no longer needs the services provided by the facility;

3. The safety of individuals in the facility is endangered;

4. The health of individuals in the facility would otherwise be endangered;

5. The resident has failed, after reasonable and appropriate notice, to pay (or to have paid under Title XIX of Title XVIII on the resident's behalf) for a stay at the facility; or

6. The facility ceases to operate.

In each of the cases described above, no patient shall be discharged or transferred without a written order from the attending physician or through other legal processes and timely notification of next of kin and/or sponsor or authorized representative, if any. Each Long-term Care Facility shall establish a policy for handling patients who wish to leave the facility against medical advice. The basis for the transfer or

discharge must be documented in the resident's clinical record. In the cases described in the clauses (a)1. and (a)2., the documentation must be made by the resident's physician, and in the case described in clause (a)4. the documentation must be made by a physician. For purposes of clause (a)5., in the case of a resident who becomes eligible for assistance under Title XIX after admission to the facility, only charges which may be imposed under Title XIX shall be considered to be allowable.

When a patient is transferred, a summary of treatment given at the facility, condition of patient at time of transfer and date and place to which transferred shall be entered in the record. If transfer is due to an emergency, this information will be recorded within forty-eight (48) hours; otherwise, it will precede the transfer of the patient.

When a patient is transferred, a copy of the clinical summary should, with consent of the patient, be sent to the Long-term Care Facility that will continue the care of the patient.

Where an involuntary transfer is proposed, in addition to any other relevant factors, the following factors shall be taken into account:

(i) The traumatic effect on the patient.

(ii) The proximity of the proposed Long-term Care Facility to the present facility and to the family and friends of the patient.

(iii) The availability of necessary medical and social services at the proposed Long-term

Care Facility.

(iv) Compliance by the proposed Long-term Care Facility with all applicable federal and state regulations.

(b) Pre-Transfer and Pre-Discharge Notice - Before effecting a transfer or discharge of a resident, a Long-term Care Facility must:

1. Notify the resident (and, if known, a family member of the resident or legal representative) of the transfer or discharge and the reasons therefore.

2. Record the reasons in the resident's clinical record (including any documentation required pursuant to (a) above) and include in the notice the items described in (d) below.

3. Notify the department and the long-term care ombudsman.

4. Not transfer or discharge a resident until the above agencies have designated their intention to intervene and until any appeal process is complete, should the resident request a fair hearing.

(c) Timing of Notice - The notice under (b) must be made at least thirty (30) days in advance of the resident's transfer or discharge except:

1. In a case described in (a)3. or (a)4. above.

2. In a case described in (a)2. where the resident's health improves sufficiently to allow a more immediate transfer or discharge.

3. In a case described in (a)1. where a more

immediate transfer or discharge is necessitated by the resident's urgent medical needs.

4. In a case where a resident has not resided in the facility for thirty (30) days.

In the case of such exceptions, notice must be given as many days before the date of the transfer or discharge as is practicable.

(d) Items included in notice - Each pre-transfer and pre-discharge notice under (b) must include:

1. For transfers or discharges effected on or after October 1, 1989, notice of the resident's right to appeal the transfer or discharge.

2. The name, mailing address, and telephone number of the state long-term care ombudsman.

3. In the case of residents with developmental disabilities, the mailing address and telephone number of the agency responsible for the protection and advocacy system for developmentally disabled individuals.

4. In the case of mentally ill residents, the mailing address and telephone number of the agency responsible for the protection and advocacy system for mentally ill individuals established under the Protection and Advocacy for Mentally Ill Individuals Act.

(e) Orientation - A Long-term Care Facility must provide sufficient preparation and orientation to residents to ensure safe and orderly transfer or discharge from he facility.

(f) Notice of Bed-Hold Policy and Readmission - Before a resident of a Long-term Care Facility is transferred for hospitalization or therapeutic leave, a Long-term Care Facility must provide written information to the resident and a family member or legal representative concerning:

1. The provisions of the state plan under this Title XIX regarding the period (if any) during which the resident will be permitted under the state plan to return and resume residence in the facility, and

2. The policies of the facility consistent with (g) below, regarding such a period.

(g) Notice Upon Transfer - At the time of transfer of a resident to a hospital or for therapeutic leave, a Long-term Care Facility must provide written notice to the resident and a family member or legal representative of the duration of any period under the state plan allowed for the resumption of residence in the facility.

Paragraph (9) of rule 1200-13-1.05 Providers is amended by addition of a new subparagraph (g) which shall read as follows:

(g) All Long-term Care Facilities shall establish written policies and procedures addressing admission, transfer and discharge, consistent with Medicaid General Rule, chapter 1200-13-1. These policies and procedures shall be available for inspection by the department.

The public necessity rules set out herein were properly filed in the Department of State on the 16th day of August, 1990 and will be effective from the date of filing for a period of 120 days. The public necessity rules will remain in effect through the 14th day of December, 1990.

68-1-113. Office on civil rights compliance – Sanctions. –

(a) (1) There is established as an extension of the office of Title VI compliance within the department of health an office on civil rights compliance by health care facilities.

(2) The office shall monitor, and upon receiving a complaint shall investigate, health care facilities licensed by the state to determine whether any such facility is denying any individual the full and equal enjoyment of the services, privileges, advantages and accommodations offered within such facility on the grounds of race, color or national origin.

(3) Following an investigation, if a determination is made by the office that any such discriminatory practice has occurred or is occurring, the office shall inform the health care facility of its findings and shall work with the facility to take affirmative action to ensure compliance with this section and to ensure that such health care facility shall cease and desist from such discriminatory practice.

(4) The office on civil rights compliance shall report and document any such discriminatory practice to the commissioner, the Tennessee human rights commission, and the board for licensing health care facilities.

(b) If complaints of discriminatory practices continue to be received by the office during follow-up investigations, and if the office determines that such facility has continued to engage in such discriminatory practices, the office shall forward its findings to the board for licensing health care facilities for appropriate disciplinary action. Such board shall have the authority to impose sanctions as provided in subsection (c) for violations of this section.

(c) The board for licensing health care facilities may deny, suspend or revoke the license issued to the health care facility for a violation of this section.

(d) In addition to such action by the board, the commissioner may impose a civil penalty in an amount not to exceed five thousand dollars ($5,000) for such violation.

(e) Any sanction imposed upon a health care facility by the board or the commissioner pursuant to this section shall be imposed in accordance with the provisions of the Uniform Administrative Procedures Act, compiled in title 4, chapter 5.

(f) Implementation of the provisions of this section shall be subject to funding being provided in the general appropriations act. [Acts 1988, ch. 977, §§ 1, 2.]

EXCERPTS FROM PETITIONERS' BRIEF IN THE COURT OF APPEALS

III. ISSUES PRESENTED FOR REVIEW

Under Wards Cove Packing Co. v. Atonio, 490 U. S. 642 (1989), a plaintiff seeking to establish a disparate impact discrimination violation must demonstrate that a facially neutral policy caused a significant adverse impact disproportionately affecting members of a protected class.

The first question presented in this appeal is whether plaintiffs' evidence was sufficient to support the district court's disparate impact holding, where (i) it did not compare the demographics of nursing home admissions and of qualified applicants for nursing home services, and (2) few nursing homes were affected by the policy challenged and plaintiffs' evidence did not link those nursing homes' admissions statistics to that policy.

The second question presented is whether the district court's remedy was an abuse of discretion where (1) the legal predicate underlying that remedy (i.e., the disparate impact violation) is invalid, and (2) even if the disparate impact finding were valid, the remedy is not narrowly tailored to the specific violations identified by the court and is otherwise contrary to federal law.

V. SUMMARY OF ARGUMENT

The district court's disparate impact finding is clearly erroneous. First, plaintiffs did not establish a statistically significant, cognizable disparity because, contrary to Wards Cove's principles, they did not compare the demographics of interested and qualified applicants for nursing home admissions with those of persons actually admitted to nursing homes. Second, even if plaintiffs' evidence sufficiently showed the requisite disparity, it did not establish any causal link between the Tennessee Certification Policy and that disparity. On the other

hand, the State's evidence demonstrated that not cognizable disparity existed and that there was no causal link between racial minorities' access to nursing homes and the Tennessee Certification Policy. In light of the fact that the district court's disparate impact finding was erroneous, the Linton Plan amounts to an abuse of discretion. First, its remedies go well beyond what is reasonably necessary to address any cognizable Medicaid Act violations. Second, its "lock-in" and "lock-out" provisions are inconsistent with the voluntary nature of the Medicaid program and impair nursing homes' existing Medicaid participation contracts.

EXCERPTS FROM THE AFFIDAVIT OF FRED R. BEAN

3. On July 16, 1987, I contacted Maplewood Health Care Center, Jackson, TN regarding their admission policy on behalf of an individual who had contacted me with a complaint; I was told at that time by the administrator that it is the policy of Maplewood Health Care Center to give preference to private pay patients over Medicaid patients and that this procedure was approved by the State Of Tennessee. Attached as Exhibit I is a copy of the Maplewood admission policy which was given to me by this administration on that day. I was also told by the Health Center staff that this policy had been approved by Health and Environment and Quality Assurance, both Tennessee State agencies.

4. At the same time I was given a copy of the waiting list for Maplewood Health Care Center attached as Exhibit 2. On reviewing the list it is apparent that private pay applicants had a much shorter admission waiting time than do Medicaid applicants. This policy of discrimination in the form of different admission waiting periods in favor of private pay patients and against Medicaid patients has been noticeable throughout the Development District and seems to be a common practice.

5. At the Maplewood Health Care Center all of the beds are certified as Medicaid eligible.

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EXCERPTS FROM THE MEDICAID ACT

42 U.S.C. § 1396r(c)

(4) Equal access to quality care

(A) In general

A nursing facility must establish and maintain identical policies and practices regarding transfer, discharge, and the provision of services required under the State plan for all individuals regardless of source of payment.

(5) Admission policy

(A) Admission

With respect to admissions practices, a nursing facility must-

(i) (I) not require individuals applying to reside or residing in the facility to waive their rights to benefits under this subchapter or subchapter XVIII of this chapter, (II) not require oral or written assurance that such individuals are not eligible for, or will not apply for, benefits under this subchapter or subchapter XVIII of this chapter, and (III) prominently display in the facility written information, and provide to such individuals oral and written information, about how to apply for and use such benefits and how to receive refunds for previous payments covered by such benefits;

(ii) not require a third party guarantee of payment to the facility as a condition of admission (or expedited admission) to, or continued stay in, the facility; and

(iii) in the case of an individual who is entitled to medical assistance for nursing facility services, not charge, solicit, accept, or receive, in addition to any amount otherwise required to be paid under the State plan under this subchapter, any gift, money, donation, or other consideration as a precondition of admitting (or expediting the admission of) the individual to the facility or as a requirement for the individual's continued stay in the facility.

(B) Construction

(i) No preemption of stricter standards

Subparagraph (A) shall not be construed as preventing States or political subdivision therein from prohibiting, under State or local law, the discrimination against individuals who are entitled to medical assistance under the State plan with respect to admissions practices of nursing facilities.

10/13/87

TRIAL EXHIBIT D-5 TO THE TESTIMONY OF POLLY T. DARNALL

DISTRIBUTION OF NURSING HOME BEDS: OCTOBER 7, 1987	In Facilities Certified for Medicare/ Medicaid	In Facilities Not Particiing [*sic*]	Among All Licensed Facilities
A. Tennessee, Statewide			
Total Number of Nursing Homes	272	14	286
Number of Nursing Homes 100% Certified	209		209
Nursing Home Beds			
Intermediate Care (ICF)	24,642		24,642
Skilled Nursing (SNF)	2,340		2,340
Dually-Certified (SNF/ICF)	2,415		2,415
Subtotal, Certified Beds	29,397		29,397
Licensed, But Not Participating	2,051	604	2,655
Total Number	31,448	604	32,052

10/13/87

TRIAL EXHIBIT D-5 TO THE TESTIMONY OF POLLY T. DARNALL (continued)

DISTRIBUTION OF NURSING HOME BEDS:
OCTOBER 7, 1987

	In Facilities Certified for Medicare/ Medicaid	In Facilities Not Particiing [*sic*]	Among All Licensed Facilities
B. Davidson County, Tennessee			
Total Number of Nursing Homes	19	3	22
Number of Nursing Homes 100% Certified	7		7
Nursing Home Beds			
Intermediate Care Facility (ICF)	1,880		1,880
Skilled Nursing Facility (SNF)	310		310
Dually-Certified (SNF/ICF)	260		260
Subtotal, Certified Beds	2,450		2,450
Licensed, But Not Participating	378	106	484
Total Number	2,828	106	2,934

* 95% of Tennessee's nursing homes choose to participate in Medicaid (272 of 286).

* 77% of Tennessee's nursing homes who participate in Medicaid have certified all their eligible beds (209 of 272).

* 7% of the licensed beds in nursing homes who participate in Medicaid are non-certified, distinct-part, and private-pay (2,051 of 31,448).

* Among the nursing homes who participate in the Tennessee Medicaid program, 93% of their beds are fully-certified and eligible for Medicaid reimbursement (29,397 of 31,448).

* Of the nursing homes who participate in the Medicaid program, 63 have elected not to seek certification of 2,051 beds, an average of 33 in each home.

* 86% of Davidson County's nursing homes choose to participate in Medicaid (19 of 22).

* 84% of all the nursing home beds in Davidson County are fully certified to participate in Medicaid (2,450 of 2,934).